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HIV PREVENTION PLANNING COUNCIL

1995

Agendas and Minutes prior to July 13, 1995 are not available.

Agendas are also missing for August 10, November 9, and December 7.

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HIV PREVENTION PLANNING COUNCIL
MINUTES
JULY 13, 1995

MEMBERS PRESENT
Ana Claire Meyer
Yvonne Littleton
Hank Wilson
Dominic Perez
Kiki Whitlock
Thomas Eades
Joshua Volle
Yesenia Aguirre
Karen Hart
Robert Hays
Jacqueline McCright
Lidia Mena-Hermida*
Wolfgang Stuwe
Bruce Occena
Valerie Kegebein

MEMBERS ABSENT
Rafael Chang
MacArthur Flournoy
Paulina Goetz
Cynthia Gomez
Robert Hernandez
Kerrington Osborne
Les Pappas
Juan Rodriguez
Wayne Sauceda
Jim Stillwell
Phillip Tse
Dan Wohlfeiler
Roslyn Allen
Jonathan Brown

AIDS OFFICE STAFF:
Geoffrey Henderson
Tracey Packer
Susan Sherman

GUESTS:
Bethsaida Ruiz, Women's Needs Center
Marcos Buñales, Street Outreach Services Program and18th St. Services

HARDER + CO./POLARIS:
Lyn Paleo
Rick Green
Mary Irvine

1. WELCOME AND INTRODUCTIONS:
   Meeting called to order at 4:15pm, by Co-Chair Valerie Kegebein.

2. MINUTES OF MAY 11, MAY 25, JUNE 8, and JUNE 22:
   Approval of these minutes put off until a quorum could be reached.

3. ANNOUNCEMENTS:
   a) Valerie: Reading of resignation letter from Ron Stall, who has had to resign his seat on the Council because of conflicting work schedules, but expresses his support and admiration for the Council. Valerie indicated that, as other resignation letters were received, they would be shared with Council members, if members so request.

* Lidia wishes to dedicate this Council meeting to two of her clients who just died within the past two weeks. One was a young Latino who received his HIV-ab test results from her years ago, and the other was the first heterosexual Latina to whom Lidia gave a positive test result.

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b) Valerie: The RFP for Technical Assistance Around Organizational Development, which is part of the Supplemental Application, will be released in the next week or so.

c) Valerie: The following seven contracts were awarded as part of the Supplemental Application (indentation followed by the – symbol indicates subcontractors):

Westside Community Health ----- for women who have sex with male IDUs
Black Coalition on AIDS
–Institute for Community Health Outreach (ICHO)

Living Well, formerly G-CHP ----- for young men who have sex with men
Stop AIDS Project
–Brothers Network
–Proyecto Contra Sida por Vida

Haight-Ashbury Youth Program----- for cocaine and amphetamine IDUs
Black Coalition on AIDS
UCSF Urban Health Study
–Haight-Ashbury Free Clinic / ICHO Street Outreach Services Program

A discussion followed about funding for these contracts, and Valerie explained that the CDC has given permission to extend these contracts into Contract Year 1996. The funding must be encumbered by December 31 1995, but does not have to be expended by that date, as previously thought. The contracts will be granted an additional six month period of funding, dependent upon the 1996 awards from the CDC.

d) Valerie: The Evaluation Task Force of the HPPC is finishing up its work on the standard variables, with a finalizing meeting on July 20, from 2:30 to 4pm -- before the regular HPPC Subcommittees meeting in the AIDS Office. This meeting will decide the common process and outcome variables that *all* providers will be asked to collect, as well as the variables that will be required of certain providers, depending on the kind of intervention they are doing.

e) Geoffrey Henderson discussed the contents of a Memo he distributed to all present at this meeting. He and Jackie Peterson are developing a research plan for a study they are conducting to fulfill the priority needs identified by the HPPC Supplemental Task Force. The study will focus on women who have sex with men who have sex with men. Currently, Geoff and Jackie are trying to put together an advisory committee for the study and to establish community contacts. A major issue for the study will be accessing the subject population. See AIDS Office Memo of 7/13.

f) Lyn Paleo discussed the contents of her Request for Data, distributed before this meeting to the Priority-setting Subcommittee and available to all other HPPC members as well. Lyn has been working with the Subcommittees to provide technical assistance. She is currently seeking any information that people have on the frequency with which an average person in a given population (behavioral, ethnic, and/or age group) engages in a given sex act. She is also trying to uncover the relative risk, or infectivity rate, of each of these acts. Information on the influence of co-factors (like self-esteem issues, depression, poppers, etc.) will also be of value to her. She is already in contact with

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about a dozen researchers around the country, but could use any leads that Council members or their associates might be able to offer. Contact Lyn Paleo -- **Phone: 243-9940. Fax: 243-0662.**

In brief response to a member's question about why she is seeking this information, Lyn explained that the plan of the Priority-setting Subcommittee has been to multiply the frequency of the act by its infectivity rate to get a raw score. Next, they will take the raw scores and adjust them to account for other community conditions and considerations, such as poverty and STDs. Other issues, like mental health stressors and self-esteem, will also be taken into account.

g) Valerie: The State Office of AIDS has sent notification that they have assigned Harold Rasmussen as the new Prevention Chief. He will replace Wayne Sauceda as the State member and should begin attending our meetings soon.

h) Hank Wilson: There is a community meeting, sponsored by Walden House, on speed in the gay community. The meeting is at Walden House (15th and Mission), July 14 at 1pm.

4. EVALUATION OF THE PLAN:

Susan Sherman announced that she has almost finished the guide she has been writing for the HPPC Prevention Plan. The guide is informed by a very close reading of the Plan and by about a dozen interviews. She expects that the guide will be sent out to providers, and will clarify the language, format, and data in the Plan. Every chapter of the guide has cross-tabulations, showing which populations at risk are listed on which pages in the Plan, so that a provider can do a quick search for information regarding her/his target population(s).

Susan also called the Council's attention to the upcoming training on the 25th, which has been posted as a "Bidder's Workshop". She stressed that this meeting will actually provide important training -- on how to use the Plan, how to access research, and how to understand the research accessed. There will be group exercises and research presentations. Tracey Packer will present on Process and Outcome Evaluation, and Valerie Kegebein will give an overview of the history of the planning process. Council members are encouraged to come to this training (which is mandatory for all prevention providers currently receiving funding from the AIDS Office -- each of these is required to send a representative), and to invite others from their organizations as well. The workshop will take place on July 25 at St.Mary's (1111 Gough), in Hall B, from 1:30 to 5:30pm.

5. YEAR ONE EVALUATION:

This agenda item was skipped, since Kathleen Roe was inadvertently scheduled in error.

6. PUBLIC COMMENTS:

No public comments were made at this time.

7. SHORT BREAK:

The Council took a break of a few minutes, since just one more person was required to make a quorum, allowing for approval of past minutes.

8. MINUTES OF MAY 11, MAY 25, JUNE 8, and JUNE 22:

All minutes were approved by the quorum without changes. Concerns and suggestions about these minutes can still be submitted to Valerie Kegebein. **NOTE: Council members have until the meeting of July 27, 1995 to request changes or corrections to these minutes.**

Ana Claire had a question about the "Reggie System" mentioned in the Revised Agenda for the June 8 meeting. Valerie answered that the HPPC meeting on July 27 will include presentations on the Reggie System and on two separate studies: the women's study mentioned above in Announcement (e), and a linkages study having to do with referrals to testing. The presentation by Kathleen Roe, which was put on the agenda for today, will also be part of the July 27 meeting.

A question was asked about the nominations for new members. Valerie responded that the Nominations Committee will have a meeting on July 26, to replace nine individuals who have left the HPPC, with people from similar areas of expertise. She pointed out that no letters were received regarding the request that was put out for a new Council Co-Chair to replace Cynthia Gomez. A brief discussion of youth representation and the importance of mentoring within the Council followed.

At about 5:10pm, the Council was adjourned so that Subcommittees could meet.

Recorded: Mary K. Irvine
Approved: Valerie Kegebein

All Meetings of HPPC and Related Subcommittees

AUGUST 1995

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3 PSS 4-8pm SIS 4:30-6pm at AO	4	5
6	7	8	9	10 HPPC 4-6pm at St. Mary's	11	12
13	14	15	16	17 PSS 4-6pm SIS 4:30-6pm at AO	18	19
20	21	22	23	24 HPPC 4-6pm at St. Mary's	25	26
27	28	29	30	31		

END OF JULY 1995

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				27 HPPC 4-6pm at St. Mary's PSS 2-4pm	28	29
30	31					

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HIV PREVENTION PLANNING COUNCIL MEETING

July 27, 1995
4:00 to 6:00 p.m.
Conference Center at
St. Mary's Cathedral
1111 Gough Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Cynthia Gomez
Valerie Kegebein
Kerrington Osborne

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Agenda

1. Welcome & Introductions	Cynthia Gomez	4:00-4:05 PM
2. Minutes of 7/13/95	Cynthia Gomez	4:05-4:10 PM
3. Discussion of Reggie System	Jan Gurley	4:10-4:25 PM
4. Linkages Study	Rani Marx/Jan Gurley	4:25-4:45 PM
5. Break		4:45-4:55 PM
6. Year One Evaluation	Kathleen Roe	4:55-5:25 PM
7. Discussion of Sex Club Ordinance	Tracey Packer	5:25-5:40 PM
8. Public Comments		5:40-5:50 PM
9. Announcements	Kerrington Osborne	5:50-5:55 PM
10. Evaluation	Kerrington Osborne	5:55-6:00 PM

Upcoming Subcommittee Meetings

Priority Setting – Thursday, August 3, 1995, 4-6 pm, AIDS Office, 25 Van Ness Ave., 5th Floor
Strategies and Interventions – Thursday, August 3, 1995, 4:30-6:00pm, AIDS Office, 25 Van Ness Ave., 5th Floor

HIV PREVENTION PLANNING COUNCIL
MINUTES
JULY 27, 1995

MEMBERS PRESENT
Jonathan Brown
Rafael Chang
Paulina Goetz
Cynthia Gomez
Robert Hays
Valerie Kegebein
Yvonne Littleton
Jacqueline McCright
Lidia Mena-Hermida
Ana Claire Meyer
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Karen Hart
Robert Hernandez
Les Pappas
Dominic Perez
Harold Rasmussen
Juan Rodriguez
Jim Stillwell
Wolfgang Stuwe

AIDS OFFICE
Lyn Fischer-Ponce
Brian Dobrow
Delia Garcia
Dr. Jan Gurley
Marshia Herring
Tracey Packer
Susan Sherman
Judith Klain

GUESTS
Bethsaida Ruiz, Women's Needs Center
Charles Smith, HPPC Evaluation Team

HARDER + CO./POLARIS
Lyn Paleo, Harder + Co.
Eden Tanovitz, Harder + Co.
Mary Irvine, Polaris

1. WELCOME AND INTRODUCTIONS:

Completed. Meeting called to order at 4:17pm, by Co-Chair Cynthia Gomez. The guests, including Eden Tanovitz of Harder + Co., were briefly introduced.

2. MINUTES OF 7/13/95:

Postponed. Cynthia Gomez noted that the Council was one member short of a quorum. Approval of the minutes was put off until a quorum could be established.

QUESTIONS:

- Has there been a discussion of the contracts awarded as part of the Supplemental Application?
  Yes. The discussion that took place in the last Council meeting was recorded in the minutes of July 13.
- What are the specific amounts awarded to the contractors? (Valerie Kegebein offered to supply this information in these minutes.) *The amounts are as follows:*

Contractual Augmentations for Unmet Needs:

a)Out-of-Treatment Injection Drug Users (IDUs)	HAFCI Youth Outreach	63,400
	BCA	29, 835
	HAFCI/ICHO	105,000
	UCSF Urban Health	35,098
b)Young Men Who Have Sex With Men	GCHP Living Well	244,542
	Stop AIDS Project	88,791
c)Female Partners of Male IDUs	BCA/ICHO	125,359
	Westside	207,975

3. DISCUSSION OF REGGIE SYSTEM:

Completed. Valerie Kegebein introduced Dr. Jan Gurley, Chief of the AIDS Ofiice Health Services and Prevention Branch, as the speaker for the Reggie System presentation. Dr. Gurley explained that the name of the Reggie System was chosen both to honor Reggie Williams and because it is a system of client registration. While the funding behind its production comes from health services, the Reggie System will have some impact on both prevention services and health services. The Health Services Planning Council had identified a problem in the usual requirement that clients undergo a separate, intensive intake process for each new service sought. Their solution was to create a uniform client registration system, linking up all services in the area, for "one-stop" care. The system will include a set of entry spaces for basic information that service providers have generally agreed upon as necessary, and a set of specialized spaces below, where agencies may input the more intensive information pertinent to their particular brand of service provision. It should take two to three years fully to develop the system; the design phase will be followed by a longer revision phase, involving input from a range of providers on different possible models of the system.

QUESTIONS:

- How will the Reggie System be able to ensure confidentiality of client information?
  A certificate of confidentiality has been issued for this project, preventing outside access to client information. In addition to the security of the certificate, all the information entered into the system will be encrypted (put into code), and clients can be registered under pseudonyms to preserve their anonymity. The specialized information entered by one agency will not be accessible to any other agency.

- Why aren't primary and secondary care separated?
  The system is simply not that sophisticated yet.

- For clients who are minors, will legal guardians have access to their files?
  There is no answer to this question yet, but that is the kind of input that will be valuable in the revision process.

4. DISCUSSION OF LINKAGES STUDY:

Completed. This is one of two studies arising from the Supplemental Application. The intent of this study is to strengthen linkages between HIV services, to assess barriers to service utilization, and to increase referrals between services. The study will look at counseling, testing, partner notification, and referral services, with an emphasis on the referral arm. Up to now, counseling and testing has had a referral system, but it has involved a complex mixture of referral styles, depending a great deal on the knowledge and attitudes of the counselors. The referrals have been irregularly recorded and conducted without systematic follow-up. A strengthened referral system could form the link to needed services for those people testing HIV negative *or* positive. The goals of this study are (1) to determine what has happened with referrals for high-risk seronegative clients, (2) to determine what barriers clients perceive to using services, and (3) to determine the actual usage of services.

5. APPROVAL OF MINUTES FROM 7/13/95:

Completed. By this time, a quorum had been established. The minutes were accepted by the Council without objections or changes.

6. BREAK (4:50-5:10pm)

Completed. The break was extended in order to find out in whether Kathleen Roe would be able to make it to the meeting, to present the Year One Evaluation. Kathleen Roe, delayed in Concord, was not able to make it.

7. DISCUSSION OF SEX CLUB ORDINANCE:

Completed. Tracey Packer opened by explaining that she works to promote HIV prevention in sex clubs, and that she has been collaborating with the Coalition for Healthy Sex to develop this ordinance. Because of the limbo status of sex clubs in San Francisco, as neither illegal nor officially legal, there has been nothing regulating their policies around safer sex practices, and no way for the San Francisco Department of Public Health to work with the clubs to promote HIV prevention. The Coalition for Healthy Sex, the San Francisco Department of Public Health, and the Office of Tom Ammiano combined forces to grant a legal status to sex clubs and standardize their operating conditions. Club owners and managers were also consulted in the production of the ordinance. It will apply to sex clubs, bathhouses (if they re-open), "private sex parties" where private organizations rent out a space for designated nights, adult theatres, adult bookstores, and adult video stores. The ordinance allows the San Francisco Department of Public Health to exercise an alternative to closing these commercial spaces for sex, in enforcing HIV risk reduction practices. The fee that sex clubs will have to pay for their permits will cover the costs of health inspections and technical assistance services. Please read the draft of the proposed ordinance, enclosed for members not present at this meeting. Public input is encouraged; contact the Office of Tom Ammiano or Tracey Packer at the AIDS Office.

Questions and concerns were raised in this discussion, regarding (1) the relatively small amount of the violation fine (will it really outweigh the financial advantages perceived by some proprietors in permitting unsafe sex practices?); (2) the vagueness of some of the legal language of the ordinance (i.e. "reasonable steps," from page 1); (3) the approval by the Coalition for

Healthy Sex of certain, questionably-safe sex clubs; (4) the levity and presumptuousness of the tone of Council members in discussing this ordinance; (5) the potential for the ordinance to become an excuse legally to wipe out the sex clubs, destroying the work toward HIV prevention in these venues; (6) the form and frequency of health inspections; and (7) the use of the term "commercial sex clubs" in the language of the document. The responses to these questions and concerns can be found on the tape of this meeting, provided for listening at the AIDS Office.

8. ANNOUNCEMENTS:

- Valerie Kegebein announced Ana Claire Meyer's sole nomination to the position of Co-Chair. Ana Claire mentioned as among her goals for the coming year increased participation at meetings and increased linkages to other planning councils and other groups whose activities overlap with ours in the city and state. She was asked what she has to offer the Council, and responded that she can offer her energy, vocal tendencies, and identifications outside of the mainstream. The nomination was approved, and Ana Claire was elected as the new Co-Chair, replacing Cynthia Gomez. Cynthia Gomez will continue to attend Co-Chair meetings, and to participate as a Co-Chair in her mentoring capacity. The reasoning behind her resignation is to get one new Co-Chair trained and experienced in the details of the job, before another new Co-Chair is elected in February. Kerrington Osborne's position will be up for election next February.

- The Nominations Committee met July 26, filled vacancies on the Council, and selected a couple of alternates. A letter has been sent to Mitch Katz requesting his approval of the nominations.

9. PUBLIC COMMENTS:

- Susan Sherman thanked the Council for welcoming her and for giving her the experience of working with this Council. This was her last meeting; she will be returning to student life. When asked about the Bidder's Workshop (7/25), she said that it was well-attended (75 people) and that it constituted a good first effort. Not everyone was prepared for the training aspect of the event, she said. The results of the workshop have been documented, and will direct the technical assistance and training provided to community-based organizations.

- Dr. Jan Gurley requests that interested HPPC members look into serving as monitors for prevention contracts. Contact Valerie Kegebein at the AIDS Office, to express interest in monitoring. A number of comments in support of contract monitoring followed Dr. Gurley's announcement.

- There will be a meeting of the Evaluation Task Force on August 23rd from 3pm-5pm, in the fifth-floor conference room at the AIDS Office. See enclosed flyer.

- Cynthia Gomez thanked the Council for the pleasure and learning experience of her term as Co-Chair. She said she has enjoyed watching this process evolve. Valerie Kegebein thanked her for her contributions.

- Valerie Kegebein explained that the AIDS Office is trying to keep everyone updated on the times and dates of Subcommittee meetings. If members want to confirm a meeting time, they can call Valerie or Tracey Packer. To make sure that an urgent message gets through quickly, dial #4# after the message or leave a message directly with the receptionist, at 554-9000.

10. EVALUATION:
Of the 17 Council members present, only 11 returned marked evaluation forms.

1.) On a scale of 1-10 (where one is "did not achieve" and ten is "fully achieved"), the achievement of the objective "to hear about and understand the Reggie System" rated at an average of 8 (with 9 of the 11 respondents answering this question).

2.) On a scale of 1-10 (where one is "did not achieve" and ten is "fully achieved"), the achievement of the objective "to hear about and understand the current status of the Linkages Study" rated at an average of 6.9 (with 10 of the 11 respondents answering).

3.) The achievement of the objective "to hear a report on the Evaluation of Year I of the planning process" cannot be evaluated, since no report was given at this meeting.

4.) On a scale of 1-10 (where one is "did not achieve" and ten is "fully achieved"), the achievement of the objective "to hear public comments" rated at an average of 7.4 (with 11 of the 11 respondents answering).

5.) On a scale of 1-10 (where one is "did not achieve" and ten is "fully achieved"), the achievement of the objective "to hear about and discuss a proposed ordinance governing sex clubs" rated at an average of 9.2 (with 11 of the 11 respondents answering).

NOTE:
The next full Council meeting will take place August 10th at St. Mary's Cathedral (1111 Gough St. @ Geary) from 4:00-6:00pm. There is no agenda for the meeting at this time.

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HIV PREVENTION PLANNING COUNCIL
MINUTES
AUGUST 10, 1995

MEMBERS PRESENT
Barbara Adler
Rafael Chang
Thomas Eades
Natalie Gutierrez
Robert Hays
Valerie Kegebein
Yvonne Littleton
Lidia Mena-Hermida
Kerrington Osborne
Les Pappas
Dominic Perez
Jay Seward
Wolfgang Stuwe
Joshua Volle
Kiki Whitlock
Hank Wilson
Bobby Wiseman
Dan Wohlfeiler

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Karen Hart
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Ana Claire Meyer
Bruce Occena
Harold Rasmussen
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Jim Stillwell
Phillip Tse

AIDS OFFICE STAFF
Lyn Fischer-Ponce
Michelle Dixon

HARDER+CO./POLARIS R. & D.
Eden Tanovitz, Harder+Co.
Amanda Houston-Hamilton, Polaris R. & D.
Mary Irvine, Polaris R.& D.

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GUESTS
Jim Naritomi, A/PAC
Annette Gaudino, ICHO
Chris Collins, CAPS/Mobilization Against AIDS
Juanita Quintero, IFR/LAS, People of Color Advisory Committee

1. WELCOME & INTRODUCTIONS

Completed. The meeting was called to order by Kerrington Osborne at 4:25pm, without a quorum. Introductions were made by all Council members, new members, AIDS Office staff, and guests present. In her introduction, Kiki Whitlock let the Council know that she was upset and frustrated to learn that no transgendered person was selected for

membership. Other members gave some detail about their areas of experience and interest, along with their community identifications.

2. INTRODUCTION OF NEW MEMBERS

Completed. Four new members attended, and some of the background information they provided to the Council by way of introduction follows:

Natalie Gutierrez works at the Institute for Community Health Outreach (ICHO), and has been active with both San Francisco Native American AIDS Projects. She can offer some perspective on the Native American community in the city, as well as in Alameda County. She has community-based organization (CBO) experience, and experience with groups that have not been as visible in the epidemic. In joining the Council, she is interested in learning what is happening with prevention on a larger scale than what she is used to.

Jay Seward has been involved a great deal with different treatment programs. He has an MPH, with a focus on epidemiology and biostatistics, from U.C. Berkeley; and he has the added perspective of a community person who is HIV positive. Through his involvement with the Council, he hopes to learn more about program evaluation and funding distribution in San Francisco.

Bobby Wiseman works with Catholic Charities and the Black Coalition on AIDS. He has professional experience in working with families and with African-American women and gay African-American men; he also has personal experience with HIV affecting his family. He is concerned with getting better represention for service consumers in AIDS/HIV agencies.

Barbara Adler started out working in an HIV testing unit, and has also run support groups and forums on HIV. She has experience in the coordination of programs and has years of experience at the test sites. She is interested in exploring the ways in which testing can and cannot function as a prevention tool. In addition, she maintains a therapy practice in the Bay Area, and can offer a mental health/psycho-social perspective. She has worked with Women Organized to Respond to Life-threatening Disease (WORLD) since its inception. The HPPC interests her in terms of the opportunities it offers to learn more about evaluation processes and about how the inner workings of the Plan will come together.

Valerie Kegebein reminded new members that she would like to get their bios, to share with the Council as a whole. Kerrington Osborne read the names of the five other candidates selected, all of whom have accepted their nominations: Rosa Benard, Rafael Diaz, Ellen Goldstein, Fernando Gomez-Benitez, and Burton Maxwell.

Discussion:

Rafael Chang requested that the Council discuss the election process. Kerrington listed the selection criteria, attached in these minutes. The other goal Kerrington mentioned of the Screening Committee process was to replace members leaving the Council with people most like them -- attempting in this way to maintain a balance of types of people and types of expertise and interest. He briefly mentioned the names and areas of

expertise of the former Council members who were being replaced. The socio-demographic makeup of the Council membership is provided in an attachment to these minutes. Lastly, Kerrington explained that the Selection Committee tried to address any deficiencies in the Council and to compensate for them.

Dan Wohlfeiler suggested that information could be provided to Council members on the nominees who were not accepted. Valerie responded that, since the 51 nominations were all confidential, she didn't want to make their identities and personal information -- such as HIV serostatus -- publicly known. Wolfgang Stuwe asked if the list of candidates would be reconsidered the next time someone leaves. Valerie responded in the affirmative, and added that there will be an opportunity for many new elections in January and February.

Kiki pointed out that she has been the only transgendered person on the Council since it began. She feels it would be important to have someone else from the transgender community present, especially a female-to-male transgendered person, since she cannot fully represent this group within the community. She added that she has felt tokenized, and explained that the transgendered population does not show up in the epidemiological profile, because there has been no commitment made to representing this group. She asked the Co-chairs to give some explanation of why there was no effort made at increasing representation of transgendered persons on the Council. Kerrington and Valerie explained the challenges of trying to meet the CDC guidelines of parity, inclusion, and representation across all five categories (shown in the list of criteria). Kerrington stressed that everyone brings something to the table that is significantly different from what any of the other members can bring, and that each of the nominees was carefully considered. Valerie added that all members are asked to represent many views, and that often they are asked to represent more than one community at a time.

Wolfgang made a request that the meeting process move on at this point. He added that he recognized the importance of Kiki's point, but also wanted to welcome the new members at the meeting and show support for their elections to the Council. Kiki closed the discussion by explaining that she feels she has done all she can for the HPPC, and that she would give up her seat just to allow another transgendered person the opportunity to occupy her seat when she leaves (if only one transgendered person can sit on the Council at a time).

3. MINUTES OF 7/27/95
Postponed. A quorum had not yet been established.

4. PRIORITY-SETTING SUBCOMMITTEE REPORT
Completed. Joshua and Rafael, Co-Chairs of the Priority-setting Subcommittee, began the presentation by explaining that it has been difficult to decide on the formulas and steps for determining which will be the priority groups for San Francisco. They asked that the presentation be considered an update on their work-in-progress.

Joshua explained that prioritization will take place in a four-phase process. Phase I takes shape in the matrix (enclosed with these minutes). The matrix is a grid showing the frequency of behaviors within specific populations and the relative risk of those behaviors for transmission of HIV. The multiplication of these two factors produces a basic score for each of the groups at risk.

Phase II of the prioritization process factors into the basic score the prevalence of HIV within a particular group practicing risk behaviors. Phase III takes the modified score and folds in the presence of co-factors increasing the likelihood of risky behavior within certain populations. In Phase IV, community members applying for funds for their programs can have some input into the final score determining their eligibility and priority for funding. It is at this point that other factors pertinent to the population group targeted can appear as alterations to the score. If, for example, a particular intervention targets women engaging in commercial sex with men, the argument can be made for a higher frequency of unprotected vaginal, anal, and/or oral sex than the frequency assigned to WSMs as a whole. A service provider can also argue that the prevalence or the co-factors for a certain targeted community would be greater than for the general behavioral risk population of which that community is a part. If the argument is well-supported, then the score can be raised, increasing the priority of the intervention in the funding distribution process.

Rafael pointed out that the matrix does not now show race or ethnicity for the epidemiological groups identified. He explained that the Subcommittee had decided not to consider ethnicity or race as a co-factor, since it doesn't directly affect behaviors or access to services/information.

Discussion:

There was some disagreement about the role of race/ethnicity in estimating and locating communities' risk for HIV. Some felt that, like poverty or language barriers, race and ethnicity lend themselves to predictions about behaviors and access. Joshua explained that the Subcommittee had asked itself, "What are the things about being in an ethnic or racial group that do function as co-factors (such as mental health stressors, access to services, poverty, substance use, language barriers, etc.)?" In bringing out the issues associated with being a member of a particular race or ethnicity, the Subcommittee aimed for specificity and expected that race/ethnicity would not need to figure in as an independent co-factor as well. Wolfgang added that the co-factors are not yet fully worked out at this point.

Thomas Eades raised a question about the burden on the CBO to perform extra research to justify its existence and continuance. Dan Wohlfeiler asked about how the research data will be weighed in relation to field data/professional program experience. Kerrington responded that the work of the Strategies and Interventions Subcommittee will provide more guidelines for the process of prioritization. He also argued that CBOs will benefit from knowing which interventions and strategies are working for their target population(s) -- that the requirement that CBOs do evaluation and have a theory behind

their prevention approaches will strengthen their programs. The CBOs who don't currently collect data will be at a disadvantage, he said, if we don't begin to apply these guidelines uniformly across CBOs. Thomas voiced concern about the degree of specificity being demanded of CBOs in their data collection. Jay Seward supported and added to Thomas' points about difficulties in getting the kind of data privileged in these guidelines (such as incidence, about which clients often lie, and even relative risk). Valerie responded that CBOs will not be expected to provide frequency data, for example, on their target populations. They will instead be asked to contribute some **behavioral data** -- e.g. in **which** risk behaviors members of the target group engage.

Eden Tanovitz described some of the sources for the Subcommittee's data on relative risk -- articles, conversations with researchers, etc. She explained that the Subcommittee had determined that relative risk data would be more accessible than infectivity rates. The relative risk scale began with the placement of vaginal receptive intercourse at a "three."

Amanda Houston-Hamilton explained that the purpose of the scoring system is to get a baseline, or to establish some ground which would then allow people to collaborate and emphasize qualitative information (about co-factors, for example) -- then it would be up to the committee to decide on an actual score. Hank Wilson added to this point that the system has its limitations, but that it is not the only way in which risk/need will be measured. The point of the model is to allow the input of people in CBOs, so that not all data and priorities can be computer-generated.

Robert Hays reminded that both receptive and insertive behaviors spread HIV, and that the chance that someone in the community will get infected is the same for both. He felt that receptive and insertive data should be combined. Secondly, he questioned the reliability of frequency data. He said that, as a behavioral scientist, he would instead use the percentage of the population that **ever** engages in the act. Kerrington answered that the Subcommittee felt it could arrive at a more accurate figure through frequency data, but that Robert's comments will be taken back to the Subcommittee for consideration.

Dan Wohlfeiler wondered how the information in these guidelines would translate to group-level or community-level interventions. He pointed out the importance of people active in the same social groups and environments as the behavioral risk population, in communicating risk reductive information and values to those directly at risk. How would these people and their roles be prioritized for prevention information? His second point was that the Plan from 1994, which still has unfinished chapters, should be filled out and enhanced with the kind of data being gathered here. Joshua and Les Pappas both spoke to Dan's first point, with the result of clarifying the reasoning behind it (that people who are not themselves at risk can influence the behaviors of those who are at risk).

Kerrington spoke up at this point to call for input from non-Subcommittee members, since the members have had several meetings in which to bring up their concerns. There was some disagreement about this, with other members arguing that Subcommittee

process had often had to privilege the majority vote over individual comments, and that all concerns ought to be addressed at this Council meeting.

Wolfgang reminded the Council that the Plan is a fluid process, and has not yet had a trial run. Some of its practical applications will have to be worked out later. He added that money had been set aside for technical assistance to CBOs for the proposal-writing process. Kerrington and Valerie began to wrap up the discussion, stressing the time crunch of the Subcommittees in finishing their work (should be more or less complete by August 31). Joshua closed by mentioning the importance to the Subcommittee of getting any input from other Council members, and Robert seconded his point.

5. BREAK
Declined, to allow the above report and discussion more time.

6. STRATEGIES & INTERVENTIONS SUBCOMMITTEE UPDATE
Postponed, in favor of the priority-setting report and discussion; and also to allow time to prepare a real report on the Strategies and Interventions work. An outline/contents page of the Subcommittee document was handed out and will be discussed at the next meeting.

7. PUBLIC COMMENTS
Completed.

- Annette Gaudino asked where transgenders fit into the matrix. She supported the concerns of members about what the guidelines would mean for practitioners in CBOs; she added that people should be paid specifically to gather the data.

- Juanita Quintero mentioned her concern that she would be asked to document just how she knows the data on her population, and said that there is just not enough time to get this together in the two weeks or so of preparation before proposals are due. She felt that an extra percentage of funding should be allotted to programs so that they could collect the data required. Her other point was that ethnicity, age, gender, and sexual orientation do affect the ways in which providers understand risk for their target populations. She explained that demographic categories can function as shorthand for the co-factors that tend to cluster under them. For this reason, she felt that demographics ought to figure into the model somewhere.

- Valerie responded to the trend of these comments and others made throughout the discussion above with a statement about the difficulties and challenges of this Council process. "It's a new day," she said, and everyone is going to have to do things differently. Technical assistance is already being funded to help providers meet the new requirements. We will have to **prove** that prevention works now, rather than reiterating to Congress that it does and expecting money in return. She clarified that there will not be an extra set-aside pot of funding for evaluation, but that for the last few years programs have been expected to incorporate these requirements into their regular budgets; this will continue to be expected, and programs will likely have to use technical assistance providers to get evaluation

done. The completion of the Request For Proposals in 1996 for 1997 should give organizations a chance to adjust and for the Plan fully to develop.

- Thomas asked about the guidelines for what would be included in technical assistance and the amount available for this. Valerie answered that there is about $200,000 set aside for technical assistance in San Francisco for the first six months, and that an RFP is being put out for capacity-building and organizational development. Thomas also asked about where there is a dialogue occurring between CBOs, encouraging a relationship between them that involves collaboration, networking and information-sharing -- rather than just competition. The responses to his question came from Robert Hays and Barbara Adler, who talked about the role of CAPS in promoting dialogue, and from Amanda Houston-Hamilton, who mentioned the information available at the Multicultural AIDS Resource Center of California (at Polaris) on HIV/AIDS researchers. Kerrington added to the discussion of technical assistance that the Plan will serve to set guidelines for just how technical assistance is provided.

- Rafael briefly responded to Annette's question, with the note that transgenders will be included in the Plan, in terms of sexual identification.

8. ANNOUNCEMENTS

Completed.

- The 4th Annual Women and HIV Conference will feature Dr. Cynthia Gomez as a speaker, and will include a keynote address by Dr. Joycelyn Elders. See attached.
- Excerpts from the document "Using Data -- Assessing Needs: A Guide for Community Members of HIV Prevention Planning Groups" are attached FYI.
- Also available from the National Council of La Raza: a "Do's and Don'ts" booklet breaking down the community planning process. It can be ordered using the number and information on the first page of the "Using Data" piece enclosed.

9. EVALUATION (15 of the 18 members present turned in marked evaluation forms.)
1.) On a scale of 1-10, where one is "did not achieve" and ten is "fully achieved," the achievement of the objective "to meet the new members and learn about their areas of expertise and contributions to planning" rated at an average of 6.07 (with 14 of 15 respondents answering).
2.) On a scale of 1-10, where one is "did not achieve" and ten is "fully achieved," the achievement of the objective "to hear about and understand the Priority-setting Model for behavioral risk populations" rated at an average of 7.13 (all 15 respondents answering).
3.) The achievement of the objective "to hear a report from the Strategies and Interventions Subcommittee members" cannot be evaluated until the report is made.
4.) On a scale of 1-10, where one is "did not achieve" and ten is "fully achieved," the achievement of the objective "to hear public comments" rated at an average of 8.62 (with 13 of 15 respondents answering).

The Council meeting adjourned at 6:10pm. The tape is available at the AIDS Office.

CURRENT AGENDA FOR AUGUST 24TH HPPC MEETING:
(TOPICS FOR DISCUSSION)

1. Discussion of standardization for units of service
2. Discussion of collection of core demographic and behavioral variables
3. Strategies and Interventions Subcommittee report
4. Priority-setting Subcommittee follow-up report

Enclosed with minutes in this HPPC packet:

- Membership Selection Criteria
- Socio-Demographic Characteristics of HPPC Membership (as of 7/26/95)
- Phase I Matrix from the Priority-setting Subcommittee
- The 25-page working document from the Strategies and Interventions Subcommittee
- Women and HIV Conference pamphlet information
- Excerpts from "Using Data, Assessing Needs: A Guide for Community Members of HIV Prevention Planning Groups"

Note: Please bring HPPC minutes for July 27th, these minutes, the Phase I Matrix, and the Strategies and Interventions document to the Aug. 24th Council meeting.

Minutes recorded by: Mary Irvine
Approved by: Valerie Kegebein

SF

HIV PREVENTION PLANNING COUNCIL MEETING

August 24, 1995
4:00 PM to 6:00 PM
Conference Center at
St. Mary's Cathedral
1111 Gough Street (@ Geary)
San Francisco

Meeting called by: *Co-Chairs:*
Ana Claire Meyer
Valerie Kegebein
Kerrington Osborne

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Agenda

1.	Welcome & Introductions	Valerie Kegebein	4:00-4:05 PM
2.	Minutes of 8/10/95	Valerie Kegebein	4:05-4:10 PM
3.	Discussion of Evaluation Task Force Activities	Valerie Kegebein	4:10-4:25 PM
4.	Units of Service Discussion	Valerie Kegebein	4:25-4:35 PM
5.	Priority Setting Update	Rafael Chang/Committee Members	4:35-5:05 PM
6.	Strategies & Interventions Subcommittee Report	Ana Claire Meyer/Committee Members	5:05-5:35 PM
7.	Public Comments		5:35-5:45 PM
8.	Announcements	Kerrington Osborne	5:45-5:55 PM
9.	Evaluation	Kerrington Osborne	5:55-6:00 PM

Up-Coming Subcommittee Meetings

Priority Setting - Thursday, August 31, 1995, 4:00 - 6:00 p.m., AIDS Office, 25 Van Ness Avenue, 5th Floor

Strategies and Interventions - Thursday, August 24, 1995, 6:00 - 7:00 p.m. (after council meeting), St. Mary's

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SF Public Health

HIV PREVENTION PLANNING COUNCIL
MINUTES
August 24, 1995

Members Present:
Barbara Adler
Jonathan Brown
Rafael Chang
Rafael Diaz
Thomas Eades
Ellen Goldstein
Cynthia Gomez
Fernando Gomez-Benitez
Robert Hays
Valerie Kegebein
Yvonne Littleton
Burton Maxwell
Lidia Mena-Hermida
Ana Claire Meyer
Bruce Occena
Kerrington Osborne
Les Pappas
Dominic Perez
Harold Rasmussen
Jay Seward
Wolfgang Stuwe
Kiki Whitlock
Bobby Wiseman
Dan Wohlfeiler

Members Absent
Yesenia Aguirre
Roslyn Allen
Rosa Benard
MacArthur Flournoy
Paulina Goetz
Natalie Gutierrez
Karen Hart
Robert Hernandez
Jacqueline McCright
Juan Rodriguez
Jim Stillwell
Phillip Tse
Joshua Volle
Hank Wilson

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AIDS Office:
Brian Dobrow
Marshia Herring
Tracy Packer

Polaris R. & D./Harder + Co.:
Eden Tanovitz
Mary Irvine

Guests:
Dominique Leslie, Shanti
Jim Naritomi, AACAA
Crystal Catamco, AAP
Howard Kwong, AAP
Tamara Ching, AAP
Christine Tayler
Sally Hansen

The Council convened just before 4:15pm, with a quorum present.

1. WELCOME & INTRODUCTIONS
Completed.

2. APPROVAL OF MINUTES OF 8/10/95 AND 7/27/95
Completed. The minutes were approved without exception.

3. DISCUSSION OF HPPC EVALUATION TASK FORCE ACTIVITIES
Completed. Valerie explained that the HPPC Evaluation Task Force is standardizing units of service and creating a system to evaluate the impact of prevention and education work. This system of evaluation should assist us in assessing the effects of prevention programs.

In addition to the units of service categories, the HPPC Evaluation Task Force is defining variables for consistently collecting demographic data -- including socio-economic status, employment status, insurance status, housing or homelessness status, and so on.

This process is the first step in making the changes the Council recommended last year to the CDC. A group of individuals from different agencies will soon be called together to further refine the work of the HPPC Evaluation Task Force.

4. UNITS OF SERVICE DISCUSSION
Completed. A draft of the categories for units of service (enclosed in this mailing) was passed around to members. Valerie explained that these categories still need to be reconciled with those being defined by the Strategies and Interventions Subcommittee. Wednesday, August 23, was the first time this information was presented to the HPPC Evaluation Task Force members. Valerie emphasized that the categories constitute a work-in-progress. Her plan is to bring together service providers of different prevention intervention types, to determine whether or not this system is feasible to them.

Questions, Answers, and Comments (Q, A, & C)
Q: Why is Evaluation/Research in "Prevention Service Categories"?
A: Simply to give credit for work done in either one or the other area. Providers have been expected to do this work before now, but the listing of these tasks as a service category allows providers to count them as units of service in their proposals, so that part of the funding for a contract has already been allocated for research and evaluation.
C: Then they should be listed as evaluation **and** research or as two separate categories, since they can be very different tasks.
C: People at the table should really be referred to as Council members, rather than as providers or public health agencies. Those present are all giving input in their capacity as Council members, not just as members of CBOs or of the Department of Public Health.
Q: Can new members who weren't here at the last meeting tell a little bit about themselves, as the new members did for the Council last time?
A: Yes (brief explanation from Kerrington about how this was done at the last meeting).

New Members: Background Information and Interest in Council

Ellen Goldstein works as a community liason at CAPS. She serves in a translational role, bringing information from research into direct services and vice-versa. She intends to bring her bicultural perspective (uniting the culture of research with the culture of direct service) to the Council. She hopes to get a hands-on sense of community leaders' work here, to bring back to the research agenda.

Burton Maxwell works out of SF State and Bayview Hunter's Point, accessing the population of African-American IDUs. He has also been working at the Institute of Scientific Analysis, on a process evaluation of needle exchange.

Fernando Gomez-Benitez works at the Clinica Esperanza Early Intervention Program, at Mission Neighborhood Health Center. Prior to that, he worked with the population of farm workers in San Joaquin County. He can bring the perspectives of the Latino community and of immigrants in San Francisco to the Council. His professional perspective on these communities is broadened by his personal involvement with them, and he hopes to find ways to link these kinds of issues on the Council.

Rafael Diaz is a social worker and an environmental psychologist. He works at CAPS, training MDs and PhDs who want to focus their energies on HIV prevention. He also works in the Mission with the community of Latino men. He is currently reviewing behavioral HIV/AIDS-related research from the NIH. His work connects research with practice, and he is devoted as a Latino gay man to his community.

Harold Rasmussen is the new Chief of Education and Prevention at the State Office of AIDS. His other experience includes working for the SF City STD Control Clinic, for the CDC AIDS Surveillance Network in Chicago, as the CDC Project Director to CA, and as the Co-Chair of the CA Community Planning Process. He brings to the Council his experience and true commitment to community planning. He is also here to learn, since CA is at the point of evaluating the effects of community planning as it translates to community programs.

5. PRIORITY-SETTING UPDATE

Completed. Rafael reported that the Priority-setting Subcommittee is planning a full-day retreat for Weds., Sept. 6, to finalize decisions on the formula. The AIDS Office will have to mail out the draft CDC application, including the Priority-setting Subcommittee activities and outcomes, to all Council members by Sept. 8. Then the Council will vote on the acceptance of this work at the meeting on Sept. 14. Rafael may be contacted with any questions about Priority-setting, at 575-3939, ex. 323.

6. STRATEGIES AND INTERVENTIONS SUBCOMMITTEE REPORT

Completed. Tracey explained that the intent of the Subcommittee was to identify and define recommendations for the range of strategies and interventions. The goal has been to standardize these definitions enough so that providers are all speaking the same language for HIV prevention. While the Subcommittee had to categorize interventions for the purposes of definition and discussion, it is impractical to view them as so discretely organized in actual prevention work. For this reason, the categories are not meant to be understood as mutually exclusive or as encompassing all the possible aspects of each type of intervention.

Tracey summarized the components to the Subcommittee guide as follows:

1) Definitions for each intervention
2) Standards for service provision/standards of practice
3) Expected outcomes -- an intervention's anticipated results, which can be used to determine its impact and success.
4) Effectiveness data (excerpted from the State of California Prevention Plan)
    a. Cost effectiveness
    b. Outcome effectiveness

She noted that the element currently missing from the write-up is information on the theory behind each intervention.

Ana Claire described the introduction to the guide, in which general recommendations are made to apply across all types of interventions. Of these, the sections on training and evaluation are both being expanded and revised significantly. Thomas Eades added that the Subcommittee is requesting any information, such as documents from Council members on their agency procedures and requirements, that could develop the training recommendations. Ana Claire noted that the Subcommittee's next step will be to identify the characteristics of target populations and determine the most effective ways to reach them.

Questions, Answers, and Comments (Q, A, & C)

Q: What is the timeline for giving feedback on the Strategies and Interventions document?

A: Feedback should all be offered by Weds., Sept. 6. Call and/or fax Mary with suggestions, at Polaris: 777-3229 (phone), 512-9625 (fax).

Q: Are the requirements for counseling and testing the federal requirements?

A: Not yet, but the Subcommittee is just starting to incorporate the CDC requirements for the final draft.

Q: How soon can the updated version be sent out to members?

A: It will be sent with the minutes of this meeting (copy enclosed for review).

C: The difference between a pre-test and post-test counseling session could be made clearer, by defining the pre-test as a risk assessment session and the post-test as a disclosure session.

C: The priorization of strategies and interventions should look at demographic data, because the more targeted an intervention is to its specific population, the more likely it is to be effective in reducing risk behaviors.

C (responding to the C above): The demographic information will be taken into account; the Subcommittee just didn't want to make programmatic decisions for agencies about exactly how they have to reach their particular targeted population.

C: There isn't much available research on interventions, and there is much less on strategies for specific targeted groups. For that reason, we can't expect to make very specific recommendations about which interventions or strategies to use with which groups.

C: It sounds like the Subcommittee process didn't go far enough. It seems reasonable to expect that the Strategies and Interventions Subcommittee would allow us to make decisions about the differences in using certain interventions with certain populations.
C: The evaluation portion of the document should be able to say that an intervention which is not working will be pulled, and that this excision will be a good thing for the community at large.
Q: Would a provider have to respond to each of the 30 or so standards of practice for a single intervention that their program proposes to do?
A1: The Subcommittee is still working that out now. It hasn't yet determined how this guide will structure the RFP process.
A2: That comes in the Criteria-setting process later, which is the implementation phase for producing an RFP.
C: It seems important to be able to develop strategies and interventions by what we're trying to effect in the way of a change. We should push people to explain what they are targeting and, based on that, what intervention they are planning to use as a step toward what they are targeting. It is also the work of the Subcommittee to explain **why** a particular intervention is effective with a particular population.
C: The Subcommittee should recognize that multiple strategies are necessary in any process of behavioral change (rather than spending all its time on pinpointing what strategy should be used for which population).

7. PUBLIC COMMENT

Completed. The first comments were made by Dominique Leslie, as a representative at the meeting of the Transgender Community Task Force. Dominique read a letter put together by the Task Force to respond to the issue of the Selection Committee not having elected an FTM (female to male) transgendered or transsexual person to the Council. (See letter enclosed.)

Christine Tayler, also a member of the transgendered community, stood up to address the same issue, and reiterated the importance of the HPPC body as a place where all communities affected by the HIV epidemic should be represented. Christine pointed out that the transgender community encompasses all other queer communities. She argued that bigotry cannot be tolerated in any form, and especially not in San Francisco. She spoke against in-fighting in our communities, and called upon the Council to appoint an FTM member.

Tamara Ching, a transgender activist and San Francisco native, described her disappointment with the Council's selection process. She had been asked to submit her application for membership to Norm Nickens, but had recommended instead that the Council reconsider making a space specifically for an FTM member. Tamara discouraged the practice of tokenism on the Council, and noted that the California Working Group has put transgendered people in the top seven population groups at risk for HIV.

Dominique then read a letter from FTM International Director James Green, who had planned to come to this meeting but was ill (letter enclosed). James Green is himself an FTM living with HIV.

Christine described her experience in counseling close to a dozen transsexual men with HIV or AIDS, and gave an account of a particularly chilling case of discrimination against one of these men by another member of the larger queer community (his lesbian pastor). She closed by saying that the problem of discrimination is a very real problem for this group.

Tamara recommended to the Council that only agencies that have demonstrated themselves to be transgender-sensitive, or that have transgendered persons on their staff, should be given contracts to train prevention providers to work with the transgendered community. She noted that there are currently only five local agencies that hire transgendered people, and that Asian-Pacific Islander agencies are at the forefront in their hiring policies.

Kiki commented on the moving presence at this meeting of a number of transgendered people. She re-thought what she had said before about having done all she could to educate this Council, and felt that she might be able to do more, starting with giving the Council a copy of the Transgender Outlook journal for distribution. She put out a call for this kind of education on transgender issues.

There were many responses from the Council to these public comments. Members spoke to the limitations of the selection process, explaining that no decision had been made to exclude or reject the transgendered community. A distinction was drawn between the Council as a whole and the portion involved in the selection process and Committee. A response was made to the point about tokenism; members described the ways in which they also served as tokens on the Council, partly because of the practical limitations on the number of people who could sit at the table together. One member suggested that, since it takes time for full representation to occur, people wanting representation seek it at the next level -- of showing up to meetings and continuing to bring up their concerns in whatever forums exist. After Dominique again brought up the question of inappropriate pronoun usage, Valerie responded that she knew the instance that was being described, and had used the wrong pronoun by mistake, not having heard enough about the candidate in question to realize that he was FTM. A heated back-and-forth discussion, in which there were moments of agreement and support expressed by the Council and community members present, brought these results:

1) Valerie will look at current city and state surveillance data to see whether it now has a capacity to account for the transgendered community, and will report on her findings.* Part of the work of the HPPC Evaluation Task Force has been to

* Valerie reports that the Surveillance Unit at the AIDS Office has expressed its willingness to explore ways we can arrive at this information through medical records review. Kevin McKinney at the Surveillance

recommend the consistent collection of data on the various populations, including transgendered people, which have not been well-recorded in the past. This issue was of particular concern in the public comments discussion, because of the selection criteria requiring the Council to represent, as closely as possible, the profile of the epidemic as it affects populations in San Francisco. The accuracy of the profile depends on the reliability of the data collection for these populations.

2) The Council was informed that Mitch Katz, Director of the AIDS Office, has been asked to meet with members of the transgendered community, and Harold Rasmussen will also be sitting in on that process.

3) The Council considered having a discussion of the by-laws around Council membership. But on further review of tasks and activities, the Co-chairs decided to table this discussion until the application process is completed. Recommendations of changes to the by-laws require participation by all Council members, not just those present at a given Council meeting. The Co-chairs will put the discussion of the by-laws on the agenda for a future meeting.

8. ANNOUNCEMENTS

Completed.

- Valerie is recruiting current Council members to implement the orientation process for new members. The orientation will take place in September; members should expect to receive a call about the specific time.

- The evaluation includes a box about sharing written comments with the Council from this day forward.

- Beginning in September, the Council will convene in a new space -- probably the church across the street from St. Mary's. St. Mary's will be converting its meeting rooms to offices.

- Tracey announced the Transgender Forum taking place from 7-9pm on the evening of this meeting, at 651 20th St. in Oakland. Kiki was scheduled to speak at the Forum.

FURTHER PUBLIC COMMENTS *(Please refer to result #3 above for all)*

- Thomas requested that the rules around adding another member and making quorum be explained and discussed for possible revision at the next meeting. He mentioned his concern about the lack of representation of other communities, such as the deaf community, at the table.

Unit has offered to explain to HPPC members the limitations on collecting this data. Currently, HIV seroprevalence surveys do record gender identity of transgendered persons.

- Kerrington repeated that, in order to bring in more members, the by-laws would have to be changed. He asked that any suggestions from the Council be called in to Co-chairs, who will discuss how to make changes fairly.

- The possibility of taking a straw vote at this meeting, as to whether to recommend that an FTM be selected now for membership, was raised and then rejected until the next meeting -- to allow for an ordered process on reviving the by-laws and then on recommendations for inclusion of communities not currently at the table.

- There was some argument about whether the by-laws are even followed now, as in the case of rules about required attendance for membership.

- A three-part recommendation was made, that 1) the voting on the by-laws be put on the agenda for the next meeting, 2) a decision be made about enforcing attendance requirements, and 3) everyone who has something to say about the issues brought up at this meeting come to present it at the next Council meeting.

9. EVALUATION (17 of the 24 members present turned in marked evaluation forms.)
1.) On a scale of 1-10, the achievement of the objective "to meet the new members and learn about their areas of expertise and contributions to planning" rated at an average of **7.75** (with 16 of the 17 respondents answering).
2.) On a scale of 1-10, the achievement of the objective "to hear about and understand the Priority Setting Model for behavioral risk populations" rated at an average of **5.20** (with 15 of the 17 respondents answering).
3.) On a scale of 1-10, the achievement of the objective "to review and consider the Evaluation Task Force activities and recommendations" rated at an average of **5.47** (with 15 of the 17 respondents answering).
4.) On a scale of 1-10, the achievement of the objective "to hear a report from the Strategies and Interventions Subcommittee members" rated at an average of **7.63** (with 16 of the 17 respondents answering).
5.) On a scale of 1-10, the achievement of the objective "to hear public comments" rated at an average of **9.56** (with 16 of the 17 respondents answering).

The box on the back page of the evaluation, about willingness to have comments shared, was checked positively by 6 members. The other members did not check the box at all. The comments which were specifically offered up to the general Council read as follows:

- Re: Transgender Issues. I feel that it is important to finally address the issues of these communities. They have not yet been reflected in the priority criteria, epi. profile, etc.
- Kerrington should apologize to Kiki for his comment about attendance. Her attendance has been above average compared to others.
- I'm very concerned that we do not have a common understanding of how the chapters fit together, and how together they will help inform decisions to be made in the future.
- Do new members understand "old" members' expertise and what they bring to the Council?

The meeting adjourned at 6:00pm. (Recorded by: Mary Irvine. Approved by: Valerie Kegebein.)

HIV PREVENTION PLANNING COUNCIL MEETING

September 14, 1995
4:00 PM to 6:00 PM
Conference Center at
St. Mary's Cathedral
1111 Gough Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Ana Claire Meyer
Valerie Kegebein
Kerrington Osborne

Please read: Minutes of August 24, 1995
Please bring: Entire Package

Agenda

1.	Welcome & Introductions	Ana Claire Meyer	4:00-4:05 PM
2.	Minutes of 8/24/95	Ana Claire Meyer	4:05-4:10 PM
3.	Announcements	Ana Claire & Kerrington Osborne	4:10-4:15 PM
4.	Review of AIDS Office CDC Application	Valerie Kegebein	4:15-5:30 PM
5.	Break		5:30-5:40 PM
6.	Public Comments		5:40-5:50 PM
7.	Evaluation	Ana Claire Meyer	5:50-6:00 PM

Up-Coming Subcommittee Meetings

Priority Setting - Thursday, September 28, 1995, 4:00 - 6:00 p.m., St. Mary's Cathedral.

Strategies and Interventions - Thursday, September 28, 1995, 4:00 - 6:00 p.m., St. Mary's Cathedral.

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HIV PREVENTION PLANNING COUNCIL
MINUTES
September 14, 1995

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Members Present:
Rosa Benard
Rafael Chang
Rafael Díaz
Ellen Goldstein
Cynthia Gomez
Fernando Gomez-Benitez
Natalie Gutierrez
Karen Hart
Valerie Kegebein
Yvonne Littleton
Jacqueline McCright
Lidia Mena-Hermida
Ana Claire Meyer
Kerrington Osborne
Les Pappas
Dominic Perez
Juan Rodriguez
Joshua Volle
Kiki Whitlock
Susana Torricella (for Harold Rasmussen)

Members Absent:
Barbara Adler
Jonathan Brown
Thomas Lee Eades
Robert Hays
Burton Maxwell
Bruce Occena
Harold Rasmussen
Jay Seward
Wolfgang Stuwe
Phillip Tse
Hank Wilson
Bobby Wiseman
Dan Wohlfeiler

AIDS Office:
Brian Dobrow

Polaris R. & D./Harder + Co.:
Lyn Paleo, Harder+Co.
Mary Irvine, Polaris R. & D.

Guests:
W. Paul Gibson, SFDPH STD Education Unit
Tamara Ching
Connie Amarathithada
Ann Smith, Glide Goodlet & Women's HIV Outreach Awareness
Carmen Madriz, BAPAC SFGH
María Rinaldi, Instituto Familiar de la Raza
Chris Collins, CAPS/MAA
Yolanda V. Lewis, Tenderloin AIDS Resource Center & Transgender Community Task Force
Dorothy Goldstein, Mothers Organizing Mothers

The Council convened at 4:15 pm, just short of a quorum.

1. WELCOME AND INTRODUCTIONS

Completed. Rosa Benard, a new member present, introduced herself and explained some of her background and interest in the Council. Rosa used to coordinate the KOKUA (Communities of Color United Against AIDS) collaboration. She works currently as a freelancer and does caretaking for friends with AIDS. She is particularly interested in developing culturally specific messages and programs for communities of color.

2. MINUTES OF 8/24/95
Postponed for quorum.

3. ANNOUNCEMENTS

- Kerrington apologized for losing his temper at the heated HPPC meeting of August 24. He feels that, as Co-chair, he should be able to model behavior for the Council.

- The date chosen for the new member orientation was September 27th, based on the results of surveys of new members. (**Note:** Valerie has had to postpone the orientation, due to unavailability of members to attend on the 27th. A new date will be posted.)

- Valerie mentioned that written responses have been made by the Co-chairs to the letters received from the Transgender Community Task Force, FTM International, and individual Council members.

- There will be a diversity training put on by the UCSF AHP on Friday October 6, at 1855 Folsom, Room 125. The flyer is enclosed. Council members are encouraged to attend.

- Polaris Research and Development -- in collaboration with Asher-Gould, Rogers and Associates, and the NTFAP -- is beginning a statewide HIV prevention social marketing campaign. Council members were asked to participate in written surveys about the promotional strategies and collaterals being considered for the targeting of testing and prevention messages. Polaris intends to involve community providers at the front end of the campaign, incorporating feedback from surveys and meetings into the creative process of planning and producing media, events, and approaches for use in existing programs and interventions across California (survey enclosed for absent members).

- Kerrington announced the loss on September 2 of Noel Day, Founder and President of the URSA Group/Polaris Research and Development. Please see the enclosed obituary. His memorial service will take place at noon on Saturday, September 23, at Grace Cathedral.

APPROVAL OF MINUTES (from **2.** above)
Completed. The minutes were approved with the following exceptions and comments:

- Kiki asked about the statement made in the "public comments" section of the minutes, that Mitch Katz, Director of the AIDS Office, had been asked to meet with members of the transgendered community, along with Harold Rasmussen. This comment was made by a guest present on August 24, and no one present today had heard of such an event having been arranged. Valerie is seeking information on this proposed meeting. (**Note:** Valerie found that the AIDS Office and Dr. Katz have no knowledge of a request from members of the transgendered community to have the above-mentioned meeting.)

- Tamara Ching clarified that she is not on staff at the Asian AIDS Project, as it would appear in the minutes, but that she has performed as a consultant for this and many other organizations.

- A guest at the August 24 meeting was mistakenly counted twice, as herself and as Sally Hansen, a pseudonym used during the Council's opening introductions.

- The description of James Green, Director of FTM International, stated incorrectly that he was himself living with HIV. This information was misheard; my apologies for the error.

4. REVIEW OF AIDS OFFICE DRAFT OF CDC APPLICATION
Completed.
I. Valerie explained that she would present an outline of all material to be included in the application (see enclosed overview). She stated the need for HPPC feedback to make improvements and clarifications to the document, and noted that not all objectives had been made fully measurable and time-specific yet. The AIDS Office is applying for the same funding that it received for this year (this includes the base cooperative agreement and the supplemental moneys), but it requires concurrence from the Council on the application. Valerie offered to provide the Council with information on what is required of the AIDS Office, and what is required of the Council, in order to get the application approved. The application will go to the CDC on September 29.

The application is for a non-competing continuation contract, but it will still have to be approved by an external review panel (comprised of CDC project officers, community representatives, and NASTAD -- the National Alliance of State and Territorial AIDS Directors), in addition to the CDC. It had to be condensed in a 40-page document (the progress report and the application were limited to 20 pages each), so that the CDC could review all applications from grantees in time. Other pieces which will be attached to the application include: the RFP, the Draft Units of Service, the Draft Core Variables[1], progress reports from the DPH contractors, the Plan, the Guide to the Plan, and Subcommittee reports.

The content of the progress report and the application is organized according to the six categories on which the CDC has required reporting:

1) CTRPN
2) Health Education Risk Reducation (HE/RR)
3) Minority Initiatives (MI)
4) HIV Prevention in Drug Users (HPDU)
5) Public Information (PI)
6) Community Planning

II. The progress report is required to provide information on the following seven AIDS Office Administration duties, within each of the six categories listed above:

[1] See note at top of p.7

1) Monitoring
2) Evaluation
3) Program Development
4) Technical Assistance
5) RFP Development
6) Contracts Compliance
7) Grants Management

The bulleted information at the top of Page 2 of the outline shows the DPH units which offer components of CTRPN and which were each briefly accounted for in the progress report. The next set of bulleted agency/program names shows the CBOs contracting through the DPH for CDC funding for CTRPN. (Urban Health Study was not included in the draft of the progress report, but will be added to it in the revision process). UHS is asterisked in the outline because its services also include HIV Prevention for Drug Users.

The HE/RR section of the progress report provides information on the activities of the AIDS Office, in each of the seven categories. It also reports on the two studies identified by the HPPC Evaluation Task Force as necessary to supplement the work of the Council (the behavioral research on WS/MSM and the linkages study), and on the publication of the Health Survey of Lesbian and Bisexual Women (the work of Valerie Kegebein, Cynthia Gomez, Delia Garcia, and Starley Shade). Finally, this section includes reports on the activities and achievements of AIDS Office contractors receiving funding under HE/RR. The Wedge Project and AESOP provide examples of the program evaluation carried out under AIDS Office HE/RR direction.

The MI section explains AIDS Office support for the work of programs which provide culturally appropriate services to people of color, gay or bisexual people and MSMs, injection drug users, and the sexual or needle-sharing partners of these people. Again, the 7 major DPH responsibilities are detailed, and reports are made on the progress of the CBO programs funded under this initiative (see page 3 of the outline).

For HPDU, there are the AIDS Office administrative duties and reports on the CBOs listed under this funding area on page 3 of the outline. Valerie noted that the new programs for funding are UHS, which is initiating a new site for counseling and testing and risk reduction counseling as a research-based intervention; and BCA/ICHO, which is targeting female partners of male IDUs. She added that this section will call the attention of the CDC to the fact that the AIDS Office is funding a needle exchange program through the SFAF/HPS.

Public Information is a small component, consisting mainly of AIDS Office staff engaged in:

1) Materials Review (of materials and campaigns proposed by CBOs and DPH, for compliance with CDC requirements)
2) Technology Transfer (conferences, presentations, and skills-building around research in progress)

3) Early Intervention Campaign (targeting African-American -- esp. pregnant -- women, with leaflets and bus shelter media encouraging testing and early treatment)
4) Sex Club Liaison (through the Coalition for Healthy Sex)

Finally, the progress report discusses the work of the HPPC. This section touches on the AIDS Office administrative activities in the planning process and the Harder + Co./Polaris collaboration for technical and logistical support to the HPPC. It demonstrates the Council's commitment to the Five Core Objectives, listed on page 4 of the outline. Valerie commented (about the objective of fostering linkages) that the AIDS Office has understood the Plan, the Application, and the work of the Council as one entity, as inextricably linked from the start; so that it was hard to imagine a separate process of linking these components. Dr. Kathleen Roe will present The Year One Evaluation for the progress report at the October 12 HPPC meeting.

III. Valerie explained that the DPH had gone over budget (by about $85,000) for the 1996 Cooperative Agreement Application, and that adjustments were being made in the salaries of DPH personnel and in DPH programs to compensate for this overage. She stressed the commitment of the DPH to reduce the budget to its $7,447,101 mark by first making cuts in its own programs before going to its contractors for any cuts. There is already a reduction in the money going into the contracts for technical/logistical support and organizational development/capacity-building. (Draft of the budget enclosed for absent members.)

IV. The priority populations listed on page 5 of the outline represent the outcome of the Priority-setting Subcommittee retreat on September 6. Valerie anticipated that discussion of these results would take place after her presentation and during the public comments.

With regard to the section on continuation of existing programs, Valerie reiterated the intent of the DPH to allow programs sufficient time to make the changes required by the Plan. She expressed her belief that, between the State Office of AIDS funding and the general funds, San Francisco was pretty much on target in reaching the target populations identified as priority populations in the Plan. She reminded members of the technical assistance provided through the AIDS Office and through Harder + Co./Polaris, to help continuing programs meet the expectations of the Plan. The RFP will be sent out next year and will provide information on all of the changes recommended. Page 5 of the outline also summarizes the additional activities included in the application as part of providers' work in following the Plan.

V. - X. The objectives for CTRPN, Community Planning, HE/RR, MI, PI, and HPDU closely resemble the objectives of last year. These objectives are defined in the application. The outline shows the ways in which the application proposes to meet these objectives.

XI. The last area requiring discussion in the application to the CDC is the impact of the planning process. Valerie mentioned the importance of explaining some of the obstacles encountered in trying to make the changes suggested by the planning priorities. This part of the report largely deals with the successes and achievements of the planning process and the rapid implementation of changes suggested in the 1994 Plan. Valerie noted the dedication of the task forces and

committees working on this process, and of the Council and community members who participated in creating the recommendations.

QUESTIONS

Ellen asked if there were more pages to the application than the 35 pages she had received. Valerie answered that those were all the pages written so far, but that some space has been left free to incorporate the input of Council members.

Karen asked if the "men" and "women" listed in the priority populations included youths. She explained that, if these population groups were intended to include youth, the language should more clearly indicate that priority. There was some discussion of (a) whether youths could be accounted for adequately through the influence of co-factors on population priority, and (b) whether "youth" should refer to the 18-24 age group or to adolescents as well. Other members spoke up to agree with Karen that the wording of the behavioral groups implied adulthood, and to suggest the appropriateness of talking instead about "males" and "females" engaging in behaviors. Members of the Priority-setting Subcommittee emphasized that the behavioral groups constitute just one phase in the determination of target population priority, which involves other factors (like age) in its later phases.

Rafael Díaz asked what was being dropped from the DPH to balance the budget, and what were the new initiatives for which funding was being set aside. Valerie reponded that nothing, other than several staff positions, had been dropped at the DPH. The new initiatives, she explained, all derive from the Supplemental Application.

Rafael Díaz then asked whether there would be a different RFP process for existing contracts. Valerie responded that Co-chairs were meeting with the AIDS Office administration to decide how to RFP existing contracts. She repeated that all contractors are expected to compete for the funding. Agencies (DPHs and CBOs) will have had all year to begin to comply with the new guidelines.

Joshua asked about the scheduling of the Bidder's Workshops for technical assistance and training, and whether there would be enough time to learn to use the guidelines before proposals were due. Valerie explained that workshops were already taking place, and that more are scheduled for the future.

Kerrington pointed out a confusion in the wording of the new priority populations (from the 1994 San Francisco Plan) identified on page 3 of the application. He expressed concern that the parenthetical note "particularly young men of color" would be misunderstood as describing the young MSMs engaging in survival sex, instead of just describing the young MSMs who do not identify as gay or bisexual. He suggested, as a way of distinguishing between these two groups of young MSMs, the wording: "...including those who do not identify as gay or bisexual (particularly young men of color) and *those who* engage in survival sex."

Rafael Chang asked when the Council would get all of the attachments for the application. Valerie answered that the only attachment not yet distributed to the Council was the draft list of

Prevention Core Variables, which needs to be approved by the Evaluation Task Force before it can be brought back to Council. Rafael still felt that it would be important to see the particular demands being made on CBOs for evaluation, before voting on the application. Valerie repeated that this was impossible, because the variables had not yet been decided. (**Note:** Valerie subsequently spoke to Rafael and agreed to delete the Core Variables from the attachments.)

Kiki asked how transgenders were being included in the priority population groups. Valerie stated that they would be accounted for by their behaviors. Cynthia added that the Priority-setting Subcommittee wants to expand each behavioral category with information on the particular position and risk factors of transgendered persons participating in that category. The objective would be to show for each behavior any greater or lesser risk of transmission due to the physiological differences of transgendered persons. Kiki asked when that process would begin and how members of the trangendered community could participate. Joshua answered that the process could be put on the agenda for the Priority-setting meeting on Thurs., September 21 (4-6pm) at the AIDS Office. He invited interested transgendered community members to attend.

5. BREAK (5 minutes)

6. PUBLIC COMMENTS

Completed. The meeting reconvened at 5:30pm, for voting on the application to the CDC. Ana Claire asked if there were any other concerns that needed to be addressed before the vote. Rafael Díaz asked for an explanation of the number of FTEs (full-time equivalents) under community planning in the budget. Valerie explained that research, epidemiology, field coordinators for surveys, Valerie's time, Brian's time, and the educational staff time would all count as community planning. Rafael then asked about the Research Initiative, and what that would mean. Valerie responded that a task force or committee would have to be developed to determine future research priorities.

Rafael Díaz identified a common association of young MSMs of color with MSMs who don't self-identify as gay or bisexual. He wanted to acknowledge the diversity of MSMs of color who do identify as gay or bisexual, and wanted the language of the Plan to reflect this diversity as well. He expressed a concern that the guidelines for funding of programs might actually conspire in the silence around homosexuality/bisexuality in communities of color, rather than providing support to the agencies that target gay or bi-identified young MSMs of color. Kerrington responded that the language was trying to get at the need to target young men of color questioning their sexuality, but that he agreed with the need to be mindful of the potential for stereotyping population groups.

Kerrington suggested at this point that the vote on the application should include Karen's comments for revision of the language around behavioral categories, and a statement detailing the Priority-setting Subcommittee process for investigating the physiological factors putting transgendered persons at risk in each behavior category. Joshua suggested that the application should go out with a more general statement that that process is beginning, but that the next Subcommittee meeting would be the first opportunity to determine just how to include this information.

Rafael Díaz expressed hesitance to approve a budget that does not allow money for new initiatives appearing on the horizon of prevention provision. Valerie responded that the Council had made a commitment several meetings ago to form a task force to look at the current resource inventory in San Francisco. This commitment will be honored, and additional funding will be sought by the AIDS Office to match the Council priorities, if they are not matched by the existing resources. Again, the process for funding for 1997 will "wipe the slate clean," so that all providers will be expected to compete anew. Kerrington added that, under the Plan, technically everything will constitute a new initiative, since communities have not performed prevention in this manner before. Kerrington also pointed out that, except for the money reserved for research for community planning, it is not possible to set aside funding (for new initiatives, for example) with the CDC. Ana Claire responded to Rafael's concern about keeping creativity alive in prevention, explaining that the Strategies and Interventions Subcommittee is making recommendations in support of creative combinations and interpretations of the guidelines.

Rafael Chang asked how the CDC funds for California would be distributed among counties, and how San Francisco could then apply for its own funding from the CDC. Susana Torricella responded that a recommendation had just been made for the formula to distribute CDC moneys to counties. She said she expects to hear very soon what the amounts will be, and added that San Francisco and Los Angeles were capped at no more than a 10% increase from last year. Valerie offered that it seems that funding will be about equal to that of last year, but with the addition of money for the CBOs. Rafael Chang asked whether that money would include hotlines. Susana explained that there would be a separate RFP for the hotlines and other statewide initiatives.

Ana Claire requested that members stay 10-15 minutes overtime, to allow for public comment from community members. Kerrington reminded the Council members that they would be voting on whether the application reflects the progress of the planning process (with the amendments suggested by Karen and Kiki).

María Rinaldi explained that her experience as a prevention provider had shown her that many Latinas have sex with men without knowing if those men have sex with other men. She felt concerned that the behavioral model used in setting population priorities relied on knowledge of partner risk, and represented a male-focused perspective. Cynthia responded that the list of behavioral groups assumes that one partner is always HIV positive, so that the probability of transmission depends on the acts performed, not on an unknown risk factor. The hierarchy of populations is based on prevalence of AIDS in the population and actual risk behaviors (their frequency and their relative risk). Kerrington reinforced María's basic point about unknown partner risk, explaining that this became a focus of research begun last year when this issue came up in the HPPC, and that the Strategies and Interventions Subcommittee was considering the influence of "risky partners" (where risk is commonly not recognized) on intervention priority. Joshua added that the last phase of the priority-setting process also allows for tailoring parts of the basic formula in response to these kinds of influences in a given target population.

Dorothy Goldstein asked why, considering that WSMs can participate in more types (oral, anal, and vaginal) of receptive sexual behavior than MSMs can, the risk of transmission from men to

women was ranked lower than the risk of transmission from men to men. Cynthia answered that the Subcommittee had had to consider the frequency of risk acts within target populations, so that the ranking is based partly on what people can do and partly on how often they do it. She reviewed the elements included in each of the four phases making up the priority-setting process.

Ann Smith spoke in support of Karen's comment about using language that is clearly inclusive of youth. She asserted that many young adults still view themselves as youths, and not as "women" and "men." She also suggested that MTF and FTM transgendered persons should be considered in completely independent behavioral categories for prioritization.

After hearing the public comments from community members, Rafael Díaz stressed the need to train providers to use the Plan and to make a strong arguments for the priority of their target populations for funding.

Rosa asked if changes could still be made to the application after the vote today. Ana Claire replied that comments could be sent to Brian anytime up to Tuesday, September 19 at 5pm.

Dominic asked why there was a higher ranking for MSM-IDUs and MSM & W-IDUs than for MSMs -- when the factor of population size would seem likely to contribute to a higher priority for MSMs, and when MSMs would probably be engaging in anal sex at a higher frequency than MSM & W-IDUs. Kerrington responded that, while population size was considered as a factor in the ranking, the MSM-IDUs and MSM & W-IDUs were engaging in a practice of needle-sharing, which was not shared by the other MSMs and which was singled out as the single most efficient method of transmitting HIV. Valerie added that the report on the formula used by the Subcommittee had not yet been completed, and that it will be easier to see the reasoning behind the outcomes when the other aspects of the formula are clarified.

Yolanda Lewis spoke to clear up any possible doubt among Council members that FTM transgendered persons are at risk for HIV, and to stress the need to recognize FTMs with funding, research, and opportunities focused in their direction. Transgendered people do get AIDS and require assistance in preventing infections in their communities. Yolanda extended an invitation to all Council members to attend an informational meeting to be held by FTM International on Sunday, October 8 from 2-5pm. Call (510) 287-2646 (an informational voicemail #) for details.

THE VOTE

The Council was reminded that it was voting on whether to write a letter of concurrence, stating that the HPPC had reviewed the application and would support it, with the amendments prompted by Karen Hart and Kiki Whitlock. Kerrington explained that the Council has always striven for consensus; but in the absence of consensus, decisions go to a vote. After Rafael Chang had expressed his objection to accepting the attachment of unseen Core Variables, the approval of the application went to a vote by show of hands.

Concurrences: 17
Rejections: 3
Abstentions: 1

LAST ANNOUNCEMENTS

- Karen announced that the San Francisco Unified School District is working on a World AIDS Day, with a variety of planned activities. She distributed a notice (enclosed in these minutes for absent members) directed at agencies who wish to have any materials presented or displayed at the school sites.

- Kiki announced a Transgender inservice being held by the Lesbian, Gay, Bisexual, and Transgender Task Force of Community Substance Abuse Services -- on Friday, September 15 from 9am-4pm at Walden House. The inservice was organized as an opportunity to present and discuss the Transgender Protocol document put together by the L/G/B/T Task Force. CSAS-funded agencies will be mandated to follow these protocol.

The meeting adjourned at 6:15pm.

7. EVALUATION (12 of the 19 members present turned in marked evaluation forms.)
1.) On a scale of 1-10, the achievement of the objective "to meet the new members and learn about their areas of expertise and contributions to planning" rated at an average of **6.83.**
2.) On a scale of 1-10, the achievement of the objective "to hear about and understand the AIDS Office application for CDC Cooperative Agreement funding" rated at an average of **8.42.**
3.) On a scale of 1-10, the achievement of the objective "to hear public comments" rated at an average of **8.92.**

The twelve evaluation respondents responded to all three questions. There were no written comments offered up to the general Council.

Next meeting: September 28, 4-6pm at St. Mary's Cathedral.
Preliminary Agenda: Full Council meeting from 4-5pm; Subcommittee meetings from 5-6pm.
Next Subcommittee meetings: Subcommittees will meet again on October 5, in the AIDS Office.
Next Council meeting <u>after</u> September 28: October 12, at the 1st Unitarian Church -- 1187 Franklin St.

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HIV PREVENTION PLANNING COUNCIL MEETING

September 28, 1995
4:00 PM to 6:00 PM
Conference Center at
St. Mary's Cathedral
1111 Gough Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ana Claire Meyer
Valerie Kegebein
Kerrington Osborne

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Please read: Minutes of September 14, 1995
Please bring: Entire Package

Agenda

1.	Welcome & Introductions	Kerrington Osborne	4:00-4:10 PM
2.	Minutes of 9/14/95	Ana Claire Meyer	4:10-4:15 PM
3.	Announcements/Ground Rules	Valerie Kegebein	4:15-4:20 PM
4.	Public Comments		4:20-4:50 PM
5.	Break		4:50-5:00 PM
6.	Subcommittee Meetings		5:00-6:00 PM

Up-Coming Meetings

HPPC - Thursday, October 12, 1995, 4:00 - 6:00 p.m., The First Unitarian Universalist Church, 1187 Franklin Street.
Preliminary agenda: Presentation of Year One Evaluation Results by Dr. Kathleen Roe.

Priority Setting - Thursday, October 5, 1995, 4:00 - 6:00 p.m., AIDS Office, 25 Van Ness Avenue, 5th Floor.

Strategies & Interventions - Thursday, October 5, 1995, 4:30 - 6:00 p.m., AIDS Office, 25 Van Ness Avenue, 5th Floor.

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SF Dept of Public Health

HIV PREVENTION PLANNING COUNCIL
MINUTES
September 28, 1995

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Members Present:
Barbara Adler
Rafael Chang
Ellen Goldstein
Fernando Gomez-Benitez
Natalie Gutierrez
Karen Hart
Robert Hays
Valerie Kegebein
Yvonne Littleton
Jacqueline McCright
Lidia Mena-Hermida
Ana Claire Meyer
Kerrington Osborne
Les Pappas
Dominic Perez
Wolfgang Stuwe
Joshua Volle
Kiki Whitlock

Members Absent:
Rosa Benard
Jonathan Brown
Rafael Diaz
Thomas Eades
Cynthia Gomez
Burton Maxwell
Bruce Occena
Harold Rasmussen
Juan Rodriguez
Jay Seward
Phillip Tse
Hank Wilson
Robert Wiseman
Dan Wohlfeiler

AIDS Office:
Tracey Packer
Brian Dobrow

Guests:
Camille Genderella Liberty
Tony Molina
W. Paul Gibson
Jim Naritomi
Tamara Ching
Kelly Aultman
Shadow Morton
Maria Rinaldi
Patrick Jerome Forte
Laurence C. Boylan

Polaris R. & D./Harder + Co.:
Mary Irvine, Polaris R. & D.
Lyn Paleo, Harder + Co.

Kerrington called the meeting to order at 4:25pm. He briefly covered the procedures for public comment (see enclosure).

I. WELCOME & INTRODUCTIONS
Completed.

II. MINUTES OF 9/14/95
Postponed for quorum.

III. ANNOUNCEMENTS/GROUND RULES

Completed.

Ground Rules:

- Valerie explained that the clarification of ground rules had been overlooked in the beginning of the HPPC. She said that the Co-chairs had decided to lay out a set of ground rules in order to streamline public comments. However, these rules apply both to Council members and to visitors. She explained the use of the 3x5 cards for signing up to speak (the speaker writes his/her name and topic on the card and turns it in to Co-chairs before the meeting begins). If the rules and procedures outlined on the enclosed sheet are not followed, then a Co-chair will ask the person in violation to leave.

Other Announcements:

- The next meeting of the HPPC will take place on October 12, 1995, at the First Unitarian Universalist Church at 1187 Franklin St., across the street from St. Mary's Cathedral. Kathleen Roe will present the Results of the Year One Evaluation at this meeting, and all first-year members will also be invited to attend. People are advised to **park in the St. Mary's lot at 1111 Gough**, and to walk over to the meeting from there.

- Ana Claire, joined by other Council members, wished a happy birthday to Ellen Goldstein.

IV. PUBLIC COMMENT

Completed.

- *Tony Molina* spoke first, and read from the California Community Planning Working Group document enclosed (an excerpt from the CA Plan). He read the excerpt to show that the CCPWG had called for inclusion of transgendered people in HIV prevention planning, and had recognized the invisibility, stigmatization, and emotional and psychological factors contributing to risk for this population. He noted the need to include transgendered persons of all sexual orientations, since gender identity does not indicate any particular sexual orientation. He closed by mentioning two issues putting transgendered persons at higher risk: frequency of sex industry work and common use of drugs, alcohol, and other substances.

- *Camille Genderella Liberty* spoke next, underscoring the lack of transgender data in epidemiological profiles. She said that if we wait for demographic information to justify bringing representation of the transgender community to the Council, then it will never happen. When transgendered persons die of AIDS, they are not counted as transgendered. Her second point was that, as a member of the Children's Committee, she worries about the abuse of queer children with psychiatric drugs. She explained that some of these drugs are immunosuppressant, making the children who take them more vulnerable to

AIDS. She also gave witness to the hoarding of these drugs by kids who have no other way of making a living. While gay/lesbian/ bisexual/queer adult identities are no longer officially classified under a psychological disorder, queer children can still be diagnosed with "gender identity disorder" and abused by the psychiatric profession.

- *Shadow Morton* said that he is starting to understand the priority-setting process. He thinks that the transgendered community members hit a speed bump in trying to work with the structure for Phase I, because biological details and assumptions are central to this part of the priority-setting process, and transgendered persons have had their biology held against them all their lives. Shadow reiterated his desire to have the community included in this process. Regarding the available research on transgendered persons, he expressed his anger over what he had heard said and seen written about them by outsiders, and compared the information on this community to the type of information that was circulating about the gay male community in the first wave of the epidemic. His last point addressed an allusion in the priority-setting minutes to concerns about Kiki stepping away from her role as a Council member to participate in meetings as a community advocate. Shadow spoke in support of Kiki, explaining the difficulties of her position serving for so long as the sole representative of the transgender community on the Council.

- *Tamara Ching* added to Shadow's statement that, although Kiki may have appeared to be alone on the Council, she has in fact had the community behind her in all of her endeavors with the planning process. She went on to say that the transgender community is coming out everywhere, and that she has always been out in her life and her work. She urged the Council to "do the right thing and do it now." She described transgendered people as the largest population at risk that has been so underserved. In closing, she stated that the transgendered community members need to be heard, to be apprised of ground rules, and to be apprised of everything that concerns them -- rather than having people talk behind their backs.

- *Jim Naritomi*, who introduced himself as a member of the People of Color Advisory Committee (POC), had some questions about the copy he had received of the 35-page narrative of the Application to the CDC. First, he explained that the linkage between the POC and the Council has been somewhat weakened recently -- in part because the Committee has changed its membership, and in part because its members are not always represented at the Council meetings. He asked whether the Application he had received was still a draft (there were nods from the Council). He also mentioned that he did not have copies of all the attachments. Finally, he thanked the AIDS Office for mentioning the POC in the narrative, and said that the Committee will try to have members present as representatives at all of the future Council meetings. *Note from Valerie:* changes were made to the application up to and including the day it was submitted

(September 29). The changes responded to comments provided by Council members and provided in the public comment given at the September 14 meeting.

- *Maria Rinaldi* expressed concern that it was still unclear to her how the factors or co-factors of race and ethnicity were functioning in the priority-setting model.

- *Patrick Jerome Forte* introduced himself as an African-American transgendered FTM. He wondered aloud why there was not someone in his community on this Council. Identifying a plague of ignorance in San Francisco, he explained that ignorance begets fear and hate. It is bad enough, he said, to have experienced discrimination as a black person; but now he had to experience it as a transgendered person. He told the Council he had come to claim what is his, not to beg for representation. He also mentioned that he knew others in his community who had not come to this meeting because of their apprehensions about the ignorance and fear they would encounter.

Valerie asked at this point if anyone else had public comments (all of the speakers who filled out cards had spoken). No one responded, so the Council returned to the minutes.

MINUTES
The minutes of September 14 were approved without objection.

V. BREAK
The Co-chairs initiated a ten-minute break, to be followed by Subcommittee meetings.

Reminder of next HPPC meeting:
Thursday, October 12, 4:00-6:00pm, in the new location: *The First Unitarian Universalist Church*, at 1187 Franklin St. (Park as usual in the St. Mary's lot.)

Preliminary Agenda: Presentation of Year One Evaluation Results by Dr. Kathleen Roe.

Minutes Recorded by: Mary K. Irvine
Minutes Approved by: Valerie Kegebein

GROUND RULES FOR HPPC MEETINGS

- Co-Chairs Facilitate
- One Person Speaks at a Time
- No Personal Insults or Attacks
- Conversational Tone
- Respectful Communication

If these rules are not followed, you will be asked to leave.

PROCEDURES FOR PUBLIC COMMENT

- Sign Up to Speak
- First Come First Serve
- Be Succinct/Concise
- Maximum 2 Minutes
- 30 Second Warning
- When 2 Minutes are Up, the Next Person Will be Called by the Meeting Co-Chair

SF

HIV PREVENTION PLANNING COUNCIL MEETING

October 12, 1995
4:00 PM to 6:00 PM
The First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ana Claire Meyer
Valerie Kegebein
Kerrington Osborne

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Agenda

1.	Welcome & Introductions	Ana Claire Meyer	4:00-4:05 PM
2.	Minutes of 9/28/95	Ana Claire Meyer	4:05-4:10 PM
3.	Announcements - (RFP Latino MSM)	Kerrington Osborne	4:10-4:15 PM
4.	Discussion of Membership	Kerrington Osborne	4:15 - 4:25 PM
5.	Availability of State P & E Funds	Kerrington Osborne	4:25 - 4:35 PM
6.	Break		4:35 - 4:45 PM
7.	Report on Year One Evaluation	Dr. Kathleen Roe	4:45 - 5:45 PM
8.	Public Comments		5:45 - 5:55 PM
9.	Evaluation	Ana Claire Meyer	5:55 - 6:00 PM

Up-Coming Meetings

HPPC - October 26, November 9, and December 14, 1995, The First Unitarian Church, 1187 Franklin Street (@ Geary).

Priority Setting - Thursday, October 12, 1995, 2:00 - 4:00 p.m. (before HPPC meeting), The First Unitarian Church.
Thursday, October 26, 1995, 5:00 - 6:00 p.m. (after HPPC meeting), The First Unitarian Church.
Thursday, November 2, 1995, 4:00 - 6:00 p.m., AIDS Office, 25 Van Ness Avenue, 5th Floor.

Strategies & Interventions - Thursday, October 16, 1995, 8:30 - 10:30 a.m., AIDS Office, 25 Van Ness Avenue, 5th Floor.
Thursday, October 26, 1995, 5:00 - 6:00 p.m. (after HPPC meeting), The First Unitarian Church.

HPPC

NEW LOCATION!

We are now meeting at

First Unitarian Church

1187 Franklin Street (@ Geary)
San Francisco

The next meeting will be on
Thursday, October 12, 1995
from 4:00 - 6:00 p.m.

OVER

First Unitarian Church of San Francisco

1187 Franklin Street at Geary Boulevard
San Francisco, CA 94109
415-776-4580

DIRECTIONS

The map on the back of this page shows the location of the Unitarian Center, which is on the corner of Geary Boulevard and Franklin Street.

Please Note: *Unfortunately, most of the metered parking spaces along the streets near The Unitarian Center become tow-away zones at 4:00pm. If you must drive, we recommend that you park in one of the parking locations indicated on the map.*

FROM THE NORTH BAY

By Bus: Golden Gate Transit buses stop at the corner of O'Farrell Street and Van Ness Avenue. Walk one block (uphill) to Franklin, and one block right to Geary.

By Car: Drive over the Golden Gate Bridge (101 South) and take the Lombard Street exit. Follow Lombard to Van Ness Avenue; turn right on Van Ness Avenue. Follow Van Ness (past Sutter and Post) to Geary; turn right on Geary and follow one block to Franklin.

FROM THE EAST BAY

By BART/Bus: Take BART (Bay Area Rapid Transit) to the Montgomery Street station. Ride the escalator up to Crocker Plaza and take the steps to the street level. On Market Street, about 100 paces to your right, you will see a bus stop. Ride the Geary #38 bus ($1, exact change) to the stop at the corner of Geary and Franklin (one block past Van Ness Avenue). If you happen to get on the Geary "Limited" #38 bus (which bypasses the corner of Geary and Franklin) get off at Van Ness and walk uphill one block to the Unitarian Center. Ask the driver when you board whether it is a "Limited Stop" bus.

By Car: Drive over the Bay Bridge (I-80) and follow signs to the Golden Gate Bridge (101 North). Take the Mission Street/Van Ness Avenue exit. Veer right at the stop light, and get into the left lane immediately. The next stop light is Van Ness Avenue; turn left on Van Ness. Follow Van Ness Avenue (past Ellis and O'Farrell) to Geary; turn left on Geary and follow one block to Franklin.

FROM THE SOUTH BAY

By Car: Take 101 North and follow signs to the Golden Gate Bridge. Take the Mission Street/Van Ness Avenue exit. Veer right at the stop light, and get into the left lane immediately. The next stop light is Van Ness Avenue; turn left on Van Ness. Follow Van Ness Avenue (past Ellis and O'Farrell) to Geary; turn left on Geary and follow one block to Franklin.

PARKING

- Public Parking Garage on Post Street between Franklin and Van Ness.
- The Cathedral Hill Hotel on Van Ness between Post and Geary.
- The Sutter Place Garage on Sutter between Franklin and Van Ness.

OVER

SF Public Health Dept

HIV PREVENTION PLANNING COUNCIL
MINUTES
October 12, 1995

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Members Present:
Barbara Adler
Rafael Chang
Ellen Goldstein
Fernando Gomez-Benitez
Natalie Gutierrez
Robert Hays
Yvonne Littleton
Jacqueline McCright
Lidia Mena-Hermida
Ana Claire Meyer
Kerrington Osborne
Dominic Perez
Jay Seward
Joshua Volle
Kiki Whitlock
Hank Wilson
Dan Wohlfeiler

AIDS Office:
Brian Dobrow

Harder + Co./Polaris, Inc.:
Mary Irvine
Steven LaFrance
Lyn Paleo

Members Absent:
Jonathan Brown
Rafael Diaz
Thomas Eades
Cynthia Gomez
Karen Hart
Valerie Kegebein
Burton Maxwell
Bruce Occena
Les Pappas
Harold Rasmussen
Juan Rodriguez
Wolfgang Stuwe
Phillip Tse
Bobby Wiseman

Guests:
Connie Amarathithada
Tamara Ching
Patrick Jerome Forte
Paul Gibson
Christina Goette
Rachel Koteles
Jim Naritomi
Margaret O'Hartigan
Delphina Perkins
Maria Rinaldi
Kathleen Roe and son
Christine Tayler
Jessica Xavier

1. WELCOME & INTRODUCTIONS
Completed. Ana Claire convened the meeting at 4:20pm, in the chapel of the First Unitarian Church. Members, guests, AIDS Office staff, and support team staff all introduced themselves.

2. MINUTES OF 9/28/95
Postponed for a quorum.

3. ANNOUNCEMENTS
Completed.

- Paul Gibson announced the one week course, "Introduction to Planning and Evaluating HIV/STD Behavioral Intervention Programs," being held by the STD/HIV Prevention Training Center (see enclosed flyer, application, and participant assessment form for members not present at this meeting).

- Mary reminded members of the Polaris social marketing campaign provider surveys, which were distributed at the Council meeting of September 14. Polaris is still hoping to get some feedback from HPPC members, based on their experience with any of the strategies being considered or the population groups being targeted in this statewide prevention and testing promotion campaign. Anyone wishing to receive the survey may call Mary at (415) 777-3229. Those who have already taken a copy are encouraged to fill it out and return it to Mary ASAP.

- Ana Claire informed people that Robert Hernandez, a former HPPC member, had just suffered a severe bashing at Esta Noche in the Mission/16th St. area. He is recovering with relatives now. Anyone wishing to send him a message or card is encouraged to mail it to Yesenia Aguirre at Health Initiatives For Youth: 1242 Market St. 3rd Fl., San Francisco, CA 94102. She will make sure that the messages get to Robert.

- As per Valerie's request, Kerrington advised that the AIDS Office will put out an RFP in the very near future, for services to Latino men who have sex with men or who have sex with men and women. The funding was made available due to the cessation of a contract with Aguilas, formerly under the NTFAP fiscal agency. In addition, the Coalition for Immigrant and Refugee Rights and Services (CIRRS) elected to discontinue their contract serving immigrant Latino men. Therefore, the two contract amounts were combined to assure continuing programs for Latino MSM and MSM/W, the target population identified in the original RFP which was issued in 1993/94.

2. MINUTES
Quorum had been established, and the minutes were approved without exception.

4. DISCUSSION OF MEMBERSHIP
Completed. Kerrington offered a brief background on HPPC membership (see enclosed outline). After covering the history of the Council, and pointing out the continual loss of members due to resignation or poor attendance, Kerrington brought the Council's attention to the nine new vacancies created in this way. Given that the process for selection takes at least one month, the new members would be left sitting in on their first meeting in December, if the process were begun immediately. Following their selection, 14 more members would have to be replaced in January, at the end of the one-year term.

Kerrington initiated a discussion on the issue of whether to suspend the provision of the bylaws calling for quarterly membership replacement. A decision by the Council to postpone the selections would allow for the appointment of 23 new members in January. All of these new members would be able to go through the orientation together, and would begin their membership by working on the third-year process. Kerrington remarked on the practical advantages of taking this option, as opposed to leaving 9 new members to attend one or two important decisionmaking meetings in December, before they had even undergone their orientation to the process. He left the group to take up the discussion, after which there would be a vote on the suspension of the bylaws.

Lidia asked about the current number of active Council members, and received confirmation from Kerrington that there are only 28. She then asked how this deficit of members would affect the quorum for voting. Kerrington replied that the quorum adjusts to the number of active members.

Robert asked if there was any way to speed up the selection process. Kerrington responded that it is difficult to collect the nominations and establish a pool of nominees. The old pool could be revived, but it has to be checked for availability and interest. It is also difficult to schedule nine people for the Selection Committee meetings. Brian spoke up to say that the Council is ready to put out the call for new nominees -- that part of the process has been quickened.

Hank suggested that, once appointments are made, people in the community should be informed about just who sits on the Council. Early participation could be encouraged, and the performance of new members could be evaluated after the first few meetings. Hank argued that the Council should anticipate more cycles of replacing its membership, and should generally attempt to speed up its process for this. He supported bringing on the 9 new members as soon as possible.

Ellen spoke to the issue of new members' lack of orientation and lack of notice about what the commitment to the Council would entail. She noted that some of the new members were still unaware of the procedure for Subcommittee participation and membership. She stressed the importance of getting new members activated and utilized quickly. Ideally, this would mean selecting the next 9 members right away; but she expressed concern that the earlier selection might not ensure a more rapid process of orientation. Kerrington responded that the orientation for those members would have to take place in December, and that an orientation for the next set of members would follow in January.

Jay asked what would be the advantages of bringing on the 9 new members now. Lyn responded that there would be three chapters (summarizing the work of the Council and Subcommittees thus far) up for review in December. The chapters would describe decisions made, the process for decisionmaking, and issues and materials informing each decision. These chapters are being distributed and presented as a supplement, but Lyn suggested that they could be used as a draft.

Brian explained that the issue which led up to this discussion is that people becoming members will have to be brought up to speed on what the Council has accomplished. The decision in December is a crucial one. In the beginning of the third year, new members will address the Plan as a whole, and will talk about making modifications to it. Brian felt it would be important to have the current members act this year on the work they have been doing, and to bring in new members to begin the work of the third year, when it will help to have their perspective. Kerrington agreed that the tasks remaining for the end of this year will demand a very thorough understanding of the Plan, in its three separate pieces/chapters. It would be unfair to expect new members to make a coherent decision on material they were seeing for the first time. Jay added his support to the suggestion of waiting for the end of the term to select new members.

Natalie mentioned that scheduling two orientations (including the one for our newer active members) by December and another for January was also ambitious. Barbara explained her position as one in favor of as many orientations as possible. She cannot make the new member orientation scheduled for October 18, but would like to hook up with one of the upcoming orientations. If having new members join now means that there will be more orientations, then she approves. She also would like to see new people attending and participating in the meetings.

Hank commented that a delay of member selection would entail a two-month period of decisionmaking by a diminished Council body. He emphasized the need to maintain community representation through a full membership. He also suggested that an alternate orientation system

should be designed, since it is logical that not everyone will be able to attend the first orientation. A smaller orientation can provide an opportunity for more in-depth information and participation; the degree to which an orientation is useful varies from one to the next, depending on who is there.

Kerrington responded that the Council had tried one-on-one make-up orientations for new members in the past. While those had not worked, he said he was still open to a discussion of this kind of system. He reiterated his concern about bringing in a new set of people, when the Council needs to make decisions based so closely on what has been done this year. In closing, Kerrington stated that it will be necessary to evaluate what the Council would have to do to enable the 9 newest people to participate productively, for what might just be one meeting before January.

Vote:
All in favor of suspending the bylaws on the issue of replacing new members: 4
All opposed: 6
Abstentions: 7

The motion failed to pass. A solicitation for nominations will be sent out immediately and those nominees will be added to the pool we have. If approved, they will then be screened for willingness to serve on the Council. The Screening Committee will meet in November, and the nominees selected can attend as members in December.

Robert suggested that the nomination procedure could be changed, so that the person nominating a candidate finds out before submitting the nomination whether that candidate is willing to serve. This would speed up the selection process. Ana Claire and Brian responded that the Co-chairs have to check with the pool of previous nominees for their willingness, anyway, but that in the future the system Robert suggested might work well. They added that it will still take time to get the Screening and Selection Committees together for meetings.

Kerrington reminded the group that the Selection Committee will try to replace departed members with the nominees who resemble them most closely.

Rafael asked if a list of old nominees, as well as a list of new members, might be made available to Council members. Kerrington responded that in 1993 the decision was made not to release the list of nominees to the Council or the public, and that has been the policy up to now. In order to share the information on the list, nominees would have to give their permission. Kiki pointed out that the selection criteria around similarity of new members to those they replace would block representation on the Council of at-risk groups not previously represented. She said that selection should be an open process, allowing new groups to participate in the Council.

Lidia offered her assistance with one-on-one new member orientations, should they begin.

5. AVAILABILITY OF STATE PREVENTION AND EDUCATION FUNDS
Completed. The State Office of AIDS recently released an announcement of available funds to support the development of a behavioral surveillance system for one or more of four statewide priorities. The AIDS Office will submit a letter of intent, applying for $20,000 for development of a system to collect data on transgender populations, a priority identified by the HPPC in

1994/95. Applicants will be notified by October 20, if the State Office of AIDS is interested in submission of a full proposal by the AIDS Office.

6. BREAK

7. REPORT ON YEAR ONE EVALUATION

Completed. Kerrington Osborne introduced Dr. Kathleen Roe, the evaluator of the first-year HPPC process. Dr. Roe has experience in working with the Alameda County and California statewide planning groups, as well as the San Francisco HPPC.

Dr. Roe opened by introducing two of her student assistants who were in attendance. Christina Goette coordinated the interviewers for the project, and Delphina Perkins conducted interviews with HPPC members. The evaluation team consisted of Dr. Roe and seven of her students from S.F. State and San Jose State University. This meeting, Dr. Roe explained, would provide an opportunity to present back to the Council the data members had given individually to evaluators.

Before showing the slides with specific data from the bound report (report enclosed), Dr. Roe briefly discussed the one-page attachment she had distributed to members (see enclosed sheet). The bulleted items under ***Purpose*** represent the spirit of the work performed by the evaluation team. Dr. Roe said that it is her objective to make more efforts like that of the HPPC possible, because she believes strongly in the importance of gaining community participation in social policy development. She added that it has been a pleasure for her to work with this Council, which she understands to be a sophisticated and experienced group of people.

While the total evaluation counted all responses from meeting participants, the report presented shows only the responses given by members of the HPPC. More specifically, this report focuses on Question #2, as shown on the one-page handout: "What were the experiences of first year participants?" Of the 37 members on the Council, 26 provided data (making a solid 70% response rate). Two members refused to reply, one because s/he had no more time to dedicate to the Council, and the other because s/he had never felt respected or taken seriously by the HPPC. Four members planned to respond, but failed to complete the scheduled interview. Finally, the other five non-respondents on the Council were "lost," meaning that they did not return the calls of Dr. Roe or her interviewers. Dr. Roe explained that interview length varied by respondent, taking anywhere from 90 minutes to six hours. Having offered this introduction, she began to talk about the slides (all material in slides can be found in the longer report).

In her discussion of Table 1, Dr. Roe described the HPPC of San Francisco as different from other community processes she has seen -- in terms of members' greater experience with friends or colleagues lost to AIDS, with working in CBOs, with large group discussions, with provision of direct education, and with reading technical reports. However, the HPPC membership showed less experience with prevention program evaluation than other planning groups. Dr. Roe mentioned this difference as a possible reason for the frustration and difficulty commonly associated with parts of the S.F. planning process. She also described the HPPC members as a "serious" bunch of people, who approached their task without a lot of "schmoozing" around at meetings.

In the report, the verbatim or close-to-verbatim responses of members to interview questions show up in italics. Next to the italicized statements, there is sometimes a number in parenthesis, which shows how many respondents made more or less the same comment.

One point brought up by the evaluation was the confusion among members about the Co-chair positions. Dr. Roe explained that the role of Co-chairs was the least defined of all roles in the process. She also said that a number of members mentioned having felt particularly hurt or set back by gestures and expressions of the Co-chairs in meetings. Every move of the Co-chairs was watched, she said; they were the "celebrities of the process."

The interviews also revealed a mutually critical relationship between community advocates/activists and researchers/planners. These two groups often questioned each other's experience and preparedness to deal with the issues of the Council. Dr. Roe identified a subcurrent in the interviews, showing that some members felt that a particular segment of the Council was using the parliamentary procedure to disable the participation of other members.

In Table 10, Dr. Roe noted the perception among some individual members of their lack of contribution to the Council. She explained that this trend might follow from a reluctance in those respondents to praise themselves, rather than from a genuine lack of contribution. However, the results in Table 9 suggest that it might have to do with a confusion about the goal of the process and/or about where members fit into the process. Dr. Roe advised that, if this sense of non-contribution was still a problem for members this year, the Council address the issue as soon as possible. The Council could create a process to share contributions made and validate what people do as members, she said.

DISCUSSION

- Robert remarked that it was interesting for him to see the positive feedback from members, because he hears people talking so scathingly about the Council. Dr. Roe responded that this group has an attitude of seriousness about planning, and that the difficult day-to-day work may seem more valuable and worthwhile in retrospect.

- Kiki asked about the honesty of respondents in interviews. Dr. Roe replied that the subjects had nothing to gain from dishonesty, since there was no connection between the AIDS Office and the interviewers.

- Rafael asked about the accuracy of the quotes from respondents. He said he could not find his own responses as he worded them in the interview. Dr. Roe explained that, in the combination of responses, his own unique perspective may have fallen out somewhat. The italicized items are not all complete statements as people made them, but are often key phrases pulled out of the interviews. Dr. Roe added that the process of evaluation can remain open and active for as long as members want. If some of the information in this report is incomplete, she can still make changes to fill it out.

- Kerrington expressed that he was not surprised by what he saw in the report. However, he pointed out that words may have different values, depending on who says them. For example, he felt that diversity had been presented in some responses as a negative force. This view of diversity disturbed him, and he wondered why it had emerged in the group. Kathleen responded that diversity requires more energy to make a process work inclusively. While respondents often saw it as a difficult and challenging aspect of the Council, they did not necessarily see it as a drawback.

- Rafael asked if members interviewed could check their file to see how and whether their comments were included in the report. Dr. Roe replied that this would be possible, and that any members with this concern should speak to her. She added that only about a third of any one interview would end up in this report, since it is just a preliminary piece, and not the final or complete draft. The other question areas will be covered in the final draft. As Kerrington said, the evaluation will eventually make up a whole chapter in the Plan. **Kathleen Roe can be reached at: (510) 944-0570.**

8. PUBLIC COMMENT
Kerrington called for public comment, but none was made.

9. EVALUATION
The evaluation forms had been left in the AIDS Office, so no evaluation was completed this time.

The Council adjourned at 6:00pm.

Minutes Recorded by: Mary Irvine
Minutes Approved by: Brian Dobrow and Valerie Kegebein

HIV PREVENTION PLANNING COUNCIL MEETING

October 26, 1995
4:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ana Claire Meyer
Valerie Kegebein
Kerrington Osborne

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Agenda

1.	Welcome & Introductions	Valerie Kegebein	4:00-4:10 PM
2.	Minutes of 10/12/95	Valerie Kegebein	4:10-4:15 PM
3.	Announcements	Valerie Kegebein/Members	4:15-4:20 PM
4.	Priority Setting Subcommittee Report	Joshua Volle	4:20-4:30 PM
5.	Srategies & Interventions Subcommittee Report	Ana Claire Meyer	4:30-4:40 PM
6.	Public Comments		4:40-4:50 PM
7.	Subcommittee Activities		4:50-6:00 PM

Up-Coming Meetings

HPPC - November 9 and December 14, 1995, 4:00 - 6:00 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary).

Priority Setting - Thursday, November 2, 1995, 4:00 - 6:00 PM, AIDS Office, 25 Van Ness Avenue, 5th Floor.

Strategies & Interventions - Thursday, November 2, 1995, 4:30 - 6:00 PM, AIDS Office, 25 Van Ness Avenue, 5th Floor.

SF
H12
#5
10/26/95

SF "Public Health"

HIV PREVENTION PLANNING COUNCIL
MINUTES
October 26, 1995

Members Present:
Barbara Adler
Rafael Chang
Rafael Diaz
Fernando Gomez-Benitez
Natalie Gutierrez
Robert Hays
Valerie Kegebein
Yvonne Littleton
Ana Claire Meyer
Kerrington Osborne
Les Pappas
Dominic Perez
Jay Seward
Susana Torricella (attending in place of Harold Rasmussen)
Joshua Volle
Kiki Whitlock
Hank Wilson

Members Absent:
Jonathan Brown
Thomas Eades
Ellen Goldstein
Cynthia Gomez
Karen Hart
Burton Maxwell
Jacqueline McCright
Lidia Mena-Hermida
Bruce Occena
Juan Rodriguez
Wolfgang Stuwe
Phillip Tse
Bobby Wiseman

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AIDS Office:
Tracey Packer

Polaris, Inc./Harder + Co.:
Mary Irvine
Lyn Paleo
Eden Tanovitz

Guests:
Christina Badasow, Real Alternatives Program
Gustavo Cravioto, Instituto Familiar de la Raza
Juan Delgado, Instituto Familiar de la Raza

I. WELCOME & INTRODUCTIONS
Completed.
Introductions were made by all present. As other members and guests arrived, they introduced themselves as well.

II. MINUTES OF 10/12/95
Postponed for a quorum.

III. ANNOUNCEMENTS
Completed.
Valerie mentioned that two more resignation letters had been received, from Wolfgang Stuwe and Bruce Occena. Recently, Dan Wohlfeiler and Rosa Benard also handed in their resignations. This leaves the Council with 28 active members.

Then Valerie discussed what would be the tasks facing the Council after the November meeting. Last year, there were multiple subcommittees involved in developing chapters of the Plan. This year, we have the Priority-setting and Strategies & Interventions chapters to complete and other issues to resolve as well. New subcommittees will be forming in December; the Co-chairs will

announce the focus of each and will try to achieve a balance of types of expertise among subcommittee members. Members can expect to see subcommittees or task forces starting on the following topics:
1) program evaluation and research
2) membership
3) technical assistance and training
4) epidemiology and needs assessment
5) goals and objectives
6) linkages
7) bylaws
8) resource allocation
There will also be an Executive Committee comprised of the co-chairs of each subcommittee.

Valerie asked Susana Torricella to introduce herself. Susana informed members that she works with the State Office of AIDS and will be taking Harold Rasmussen's place. She will vote with the other members.

IV. PRIORITY-SETTING SUBCOMMITTEE REPORT
Completed.
Joshua introduced himself and Rafael Chang (who was not yet present) as the Subcommittee Co-chairs. He brought members up-to-date on recent decisions made by the Subcommittee, and provided a brief review of the multi-phase process for prioritization of behavioral groups. (See the attached Priority-setting Subcommittee minutes from October 26, regarding this presentation).

In the discussion following Joshua's report, Kerrington added that the Subcommittee had decided to recommend that co-factors become a required element of the RFP process. He also mentioned that the Strategies and Interventions process includes the use of co-factors (or really population characteristics, rather than co-factors for transmission) for determining intervention applicability. Some members asked about the specific issues fitting under larger co-factor categories, and Joshua responded (refer to the attached list of co-factors and key examples). Ana Claire added the example of differently abled issues for inclusion in the larger category of *Discrimination*. The co-factors list will come up for a Council vote at the next full meeting.

II. APPROVAL OF MINUTES
Completed.
A quorum approved the Council minutes of October 12 without exception. Valerie added that the AIDS Office has not yet heard from the State Office of AIDS about whether the application for additional (behavioral surveillance) funding has been reviewed. Susana Torricella had not heard about the application, and could not give insight into its status at this time.

V. STRATEGIES & INTERVENTIONS SUBCOMMITTEE REPORT
Completed.
Ana Claire told members that the Strategies and Interventions Subcommittee had endeavored to integrate elements of the Priority-setting process into its work. The Strategies and Interventions Subcommittee has decided to adjust its process of prioritization to increase the flexibility of programs. Instead of ranking interventions by population (e.g., giving the top five interventions for a particular target group), the Subcommittee is currently focusing on two tasks:
1) a statement describing the necessary components of program design

2) a guide to the applicability of particular interventions for particular population characteristics (these characteristics relate to the challenges in reaching the population with prevention, rather than the susceptibility of the population to HIV transmission -- although they may resemble co-factors)

The draft "Applicability Worksheet" (enclosed for all members not present) was distributed around the table. Ana Claire explained that the Subcommittee is about two-thirds of the way through its process of outlining applicability. This information will probably follow the California State HIV Prevention Plan effectiveness data, in the Strategies and Interventions chapter. The Subcommittee process for determining applicability has taken into consideration all sections of the chapter, as well as where the target groups are in their stages of change and their access to services.

DISCUSSION

Yvonne asked why there were no limitations for applicability of multiple session groups. Ana Claire explained that the worksheet was not completed, because the Subcommittee has not yet gotten through all the interventions.

Rafael Chang suggested that the Subcommittee review the apparent contradiction in statements about the applicability of PCM (is it or isn't it a middle-class model?). He also brought up the issue of language limitations for hotlines (this note will be added to the worksheet).

Rafael Diaz was concerned that the source of this information on "effectiveness" was unclear, and recommended that the Subcommittee clearly attribute the statements in the worksheet to the State Effectiveness data, to members' provider experience, or to whatever was being cited. Ana Claire explained that this is just a first draft, and that it has been put together from discussions in the past few Subcommittee meetings, which drew upon both the State Effectiveness data and members' professional experience.

Lyn asked whether the applicability write-up would incorporate the CDC criteria for intervention implementation. Ana Claire responded that that would be the next step in the Subcommittee process.

Yvonne brought up the question of mixing venue-based with street-based outreach in the chapter. She felt that the differences between these outreach approaches and their challenges for effectiveness should not be overlooked. Tracey explained that the rationale behind using "Venue-Based Individual Outreach" as a combined category had been to be inclusive of all the locations people frequent, and to show the value of bringing prevention to wherever members of a target group can be found. The Subcommittee did not want to limit their definition to street outreach. Ana Claire explained that there is more explanation of the specific issues for venue/street-based outreach in the chapter, and there is a category for "Venue-Based Group Outreach." Several members expressed support for Yvonne's suggestion that the street be considered independently of other venues (which differ in being enclosed spaces, where people have chosen to come for a specific purpose -- often to interact with other people).

Rafael Diaz asked if the AIDS Office has a database with information on the success of programs practicing various interventions (e.g., whether a program was able to attract clients from the target group); if available, this might give the Subcommittee a sense of intervention outcomes and viability. Valerie replied that the AIDS Office performs minimal evaluation. It has quarterly reports and monitoring at its agencies, but these do not offer the level of detail Rafael was suggesting. The monitoring focuses on whether a program is meeting its units of service (deliverables). However, some information on the meeting of intervention objectives appeared in

last year's Plan. Valerie also recommended a review of literature on the effectiveness of these interventions for preventing other diseases (not HIV).

Eden reminded the group that "effectiveness" as described in the worksheet should not be confused with the effectiveness data used in the larger Strategies and Interventions chapter. Ana Claire added that the worksheet only represents a first draft of the applicability outline; it had not been approved or even read by anyone on the Subcommittee before this meeting.

Returning to the actual text of the draft, Yvonne pointed out that "cooling off" an intervention that has been highly visible in a certain street location can cause the assumption among members of the target group that the problem is over, and that they can go back to doing whatever they were doing before they started considering their risk for HIV. She suggested that the statement on oversaturation should be modified to prevent outreach interventions from simply disappearing from their customary venues.

Bob mentioned that the Subcommittee had been discussing the applicability issues in terms of the positives and negatives of using certain interventions for populations with certain characteristics, and not in terms of the "effectiveness" or "limitations." Ana Claire responded that this wording will be changed as the draft is revised. Valerie asked that the worksheet not be read entirely out of context; it would only make up one part of the total Subcommittee document, the rest of which has been read and approved in its draft form by the Council. There was some brief confusion on the part of Council members about the larger Subcommittee document, and Ana Claire explained that it was the 30-some page piece mailed out to members with a Table of Contents, Introduction, and then descriptive sections specific to each strategy and intervention.

Kerrington voiced his thought that people might be more confused by this worksheet because of the change in the Subcommittee procedure around prioritization. Members originally expected to have a set of rankings for interventions by population group, and the final approach was much more flexible than that. This worksheet represents the Subcommittee decision to describe the applicability of interventions based on a set of distinguishing characteristics of target populations; it allows providers to set their own priorities, once they have recognized how interventions work in various situations. Rafael Diaz suggested that the worksheet could be useful to providers because it addresses the potential limitations of strategies and interventions, allowing providers to argue for their approaches to dealing with these limitations. The information on potential benefits of certain approaches can also help providers to strengthen their rationale for what they are doing.

Valerie closed the discussion, noting that the Subcommittee draft documents will be sent to the CDC by November 9, so that the external review team can see what has been accomplished by our process thus far.

VI. PUBLIC COMMENTS

Completed.

Christina Badasow spoke in support of Yvonne's and Kerrington's comments about the difference between street-based and other venue-based outreach. She explained that her experience as a provider had also demonstrated to her that the street brings prevention workers into contact with a different group of people, who are there with a different set of purposes, from the people contacted at bars and other venues. The street brings its own challenges and opportunities to the work of HIV prevention.

At this point, the Council took a short break before separating into Subcommittees.

VII. EVALUATION

Completed. (Nine out of the seventeen members present filled out evaluation forms.)

1.) On a scale of one to ten, members rated the achievement of the objective "To hear a report from the Priority Setting Subcommittee" at an average of 8.44.

2.) On a scale of one to ten, members rated the achievement of the objective "To hear a report from the Strategies & Interventions Subcommittee" at an average of 8.77.

3.) On a scale of one to ten, members rated the achievement of the objective "To hear public comments" at an average of 8.77.

WRITTEN COMMENTS

- A member pointed out that the evaluation wording does not ask whether a presentation was effective and well-understood. It might be more revealing to make the objective "To *hear and understand* the report/progress of...".
- Another member wrote:

  Finally transgendered populations are specifically included in the Priority categories. I am glad the transgender community was persistent in working with the HPPC to make sure TG persons are not ignored. Good work! I especially want to thank Harder + Co. (Lyn Paleo and Eden) for compiling research around frequency of behavioral risks for TG populations and writing the report.

Next HPPC Meetings: Thursday, November 9, 4-6pm and Thursday, December 14, 4-6pm -- at the First Unitarian Church, 1187 Franklin St. (@ Geary).

Minutes Approved by: Valerie Kegebein
Minute Recorded by: Mary Irvine

HIV PREVENTION PLANNING COUNCIL
PRIORITY-SETTING SUBCOMMITTEE MINUTES
October 26, 1995 -- 3:30pm

Members Present:
Valerie Kegebein
Kerrington Osborne
Joshua Volle
Kiki Whitlock

AIDS Office:
Tracey Packer

Harder + Co.:
Lyn Paleo

Members Absent:
Jonathan Brown
Rafael Chang
Cynthia Gomez
Yvonne Littleton
Lidia Mena-Hermida
Bruce Occena
Juan Rodriguez
Jay Seward
Wolfgang Stuwe

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Joshua convened the meeting at 3:30pm and noted the low attendance. He reviewed the Subcommittee decisions that would be presented to the HPPC:

- Phase I prioritizes behavior groups using a matrix that has the estimated average annual frequency of risk activities and an estimated relative risk value for each activity. In the presentation to the HPPC, the method for including transgender groups will be discussed. [**Note:** Joshua explained in the full Council meeting that each behavior group in the matrix had been expanded to include the transgender groups that fit the biological and behavioral characteristics of the category. For example, the group that used to show up in the matrix as **MSW** will now be listed as **MSW; MTF(pre-op)SW; FTM(post-op)SW.**]

- Phase II adjusts the Phase I score by including prevalence and population size for each behavior group. Phases I and II form the basic ranking of behavior groups.

- Phase III identifies seven categories of co-factors and provides key examples for each. The Plan will contain a general description of these co-factors. (**Note:** Joshua told the full Council that the Subcommittee had made a decision not to weight or rank the co-factors.)

- Phase IV allows providers making applications for funding to apply the Phase I process to their specific target group, and requires providers to describe the presence of co-factors in their target group (this information should be included in a needs assessment).

The Subcommittee will recommend to the AIDS Office some questions to be included in the reviewers' rating sheet, such as:

- Did the applicant adequately describe co-factors in the application?

- Did the applicant tie these issues into the proposed intervention?

PRIORITY-SETTING CO-FACTORS (LIST WITH KEY EXAMPLES):*

1.) Poverty
- ◊ financial instability
- ◊ homelessness

2.) Biological
- ◊ STDs

3.) Psychological
- ◊ mental health stressors
- ◊ history of child sexual abuse
- ◊ history of abusive relationships
- ◊ self-esteem
- ◊ rape
- ◊ social support

4.) Behavioral
- ◊ risky partner
- ◊ commercial sex workers
- ◊ substance abuse
- ◊ multiple sex partners
- ◊ discordant couples

5.) Lack of Access
- ◊ knowledge of services
- ◊ language*
- ◊ low literacy

6.) Social/Cultural
- ◊ institutionalization
- ◊ perception/lack of perception of susceptibility

7.) Discrimination
- ◊ racism
- ◊ homophobia/transphobia
- ◊ sexism
- ◊ ageism
- ◊ ablism
- ◊ classism

* This is not meant to be an exhaustive list of examples.

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Rel. Risk	12	1	0.5	9	3	2	0.002	1	0.5	2	1.5	0.1
	Sharing Dirty Needles	Giving cunn. menses	Other blood to blood	Anal Recept	Vaginal Recep.	Vag. insert. menses	Vag to vaginal menses	Giving fellatio	Giving cunn.	Anal insert.	Vaginal insert.	Getting cunn.
MSW		6 6	0			0			41 20.5	8 16	66 99	
WSM			0	6 54	62 186			33 33				37 3.7
MSM			0	21 189				9 9		21 42		
WSW		14 14	12 6				14 0.028		94 47			94 9.4
MSM/W		3 3	0	21 189		0		9 9	20 10	21 42	21 31.5	
WSW/M		16 16	14 7	9 81	46 138		16 0.032	24 24	100 50			100 10
MSW-IDU	38 456	6 6	0			0			41 20.5	6 12	82 123	
WSM-IDU	40 480		0	6 54	77 231			48 48				35 3.5
MSM-IDU	70 840		0	24 216				30 30		18 36		
WSW-IDU	40 480	14 14	12 6				14 0.028		94 47			94 9.4
MSM/W-IDU	75 900	3 3	0	7 63		0		13 13	20 10	18 36	21 31.5	
WSW/M-IDU	40 480	16 16	14 7	10 90	50 150		16 0.032	26 26	100 50			100 10

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Rel. Risk	12	1	0.5	9	3	2	0.002	1	0.5	2	1.5	0.1	0.1	0.001	0.1									
	Sharing Dirty Needles	Giving cunn. menses	Other blood to blood	Anal Recept	Vaginal Recep.	Vag. insert. menses	Vag to vaginal menses	Giving fellatio	Giving cunn.	Anal insert.	Vaginal insert.	Getting cunn.	Getting fellatio	Vag. to vaginal	Sharing unclean sex toys	Total Freq	Prev.	Total Score	Population Size	Grand Total	Pop score	Beh. Group	New Total
MSW		6 6	 0			0			41 20.5	8 16	66 99		43 4.3		0	145.8	0.09%	0.1312	252,544	331	4	MSW	0.52
WSM			 0	6 54	62 186			33 33				37 3.7			0	276.7	0.19%	0.5257	285,049	1,499	4	WSM	2.10
MSM			 0	21 189				9 9		21 42			37 3.7		0	243.7	44.99%	109.64	41,250	45,227	3	MSM	328.92
WSW		14 14	12 6				14 0.028		94 47			94 9.4		94 0.094	124 12.4	88.922	0.08%	0.0711	14,550	10	3	WSW	0.21
MSM/W		3 3	 0	21 189		0		9 9	20 10	21 42	21 31.5		37 3.7		0	288.2	33.45%	96.403	13,750	13,255	3	MSM/W	289.21
WSW/M		16 16	14 7	9 81	46 138		16 0.032	24 24	100 50			100 10		100 0.1	64 6.4	332.53	0.61%	2.0264	15,750	319	3	WSW/M	6.09
MSW-IDU	38 456	6 6	 0			0			41 20.5	6 12	82 123		42 4.2		0	621.7	13.96%	86.769	8,500	7,377	2	MSW-IDU	173.58
WSM-IDU	40 480		 0	6 54	77 231			48 48				35 3.5			0	816.5	12.15%	99.205	3,300	3,274	2	WSM-IDU	198.41
MSM-IDU	70 840		 0	24 216				30 30		18 36			30 3		0	1125	64.71%	727.99	2,250	16,380	2	MSM-IDU	1,455.98
WSW-IDU	40 480	14 14	12 6				14 0.028		94 47			94 9.4		94 0.094	124 12.4	568.92	4.35%	24.75	575	142	1	WSW-IDU	24.75
MSM/W-IDU	75 900	3 3	 0	7 63		0		13 13	20 10	18 36	21 31.5		18 1.8		0	1058.3	48.53%	513.59	750	3,852	1	MSM/W-IDU	513.59
WSW/M-IDU	40 480	16 16	14 7	10 90	50 150		16 0.032	26 26	100 50			100 10		100 0.1	64 6.4	835.53	12.00%	100.26	625	627	1	WSW/M-IDU	100.26
																						Total	

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STRATEGIES AND INTERVENTIONS APPLICABILITY WORKSHEET
(DRAFT)

Suggested Use: We recommend that providers use this worksheet as a summary of the issues around choosing interventions and strategies for a particular type of target population. An intervention may be adapted to better serve a targeted group, but the following general considerations should be taken into account for making those adaptations.

The following population factors/characteristics can influence the choice of intervention or strategy for a targeted group (these factors should be weighed in the program planning process):

Psychological
mental health stressors
- low self-esteem
- abusive relationship(s)
- rape
- history of child abuse

multiple loss

Demographic
race/ethnicity
gender
sexual identification
age and maturation/development
immigration/acculturation

Social
income status
housing status
primary language/literacy level/vocabulary
in/out of school
in/out of treatment
incarceration/institutionalization

Behavioral
drug use
commercial/survival sex

STRATEGIES

Peer Education
(a strategy, which is generally applicable to all populations, with few exceptions)
advantages/strengths
- can get people to perceive, personalize, and even identify with the risk for HIV
- can be good for populations which do not initially perceive themselves to be at risk
- can make use of a "cultural fit" between the client and the educator

considerations
- may not appeal as much to members of small/close communities where information travels fast and stigma is still attached to HIV concerns (some groups may prefer to get HIV prevention services from people they view as outside of their immediate community, so that they can talk more freely and not fear leakage of information); a looser cultural fit may be more appropriate here
- does not appeal as much to clients desiring anonymity; should emphasize confidentiality

Natural Opinion Leaders
(a strategy)
advantages/strengths
- can reach people who feel some group identification, and recognize community leaders
- can reach people who value sports stars, movie stars, and other media heroes (e.g., youth)
- can provide a breakthrough in understanding for people with low perception of personal or communal risk

• can be powerful for groups in which social stigma is heavily attached to homosexuality or injection drug use

considerations

• relies on the relationship between the chosen opinion leader and the group targeted (needs assessment)

Social Marketing

[a strategy -- still being written. Can also be an intervention in itself, **and** is important in developing interventions (test marketing) and in recruitment for other interventions (e.g., small groups).]

Community Organizing

(a strategy -- still being written. It can also be viewed as an outcome, an objective, a type of target group, an intervention, or a combination of interventions. These multiple functions and interpretations will be explained in the finished chapter.)

advantages/strengths

• can provide capacity-building for a community -- so that members can develop and model positive social norms for others in the community (educating people to become educators)

• creates networks which can then be utilized for conducting other interventions

• can address all the co-factors or population characteristics that create obstacles to HIV risk reduction

considerations

• has the power to damage, as well as to build, community networks

INTERVENTIONS

Venue-Based Individual Outreach

(a standard intervention -- the greatest challenge is to make it creative and effective)

advantages/strengths

• can be good for groups with low perception of personal risk for HIV

• can be effective for groups which lack access to services

• can be effective for any group needing basic information delivery and/or needing to hook up with services (referrals)

• can serve as an opportunity to recruit clients for other prevention activities

considerations

• may not work as well for groups facing serious mental health stressors

• may not be appropriate or allowed in certain venues (needs assessment determines feasibility)

• may not be as effective for groups which are well-informed but continue to show high rates of infection

• may lose its impact if it is overconcentrated in a venue -- after saturating a venue over a period of time, the intervention should adapt to prevent desensitization (either through a less aggressive outreach presence or through a creative change in how the intervention is performed)

• cannot always meet clients' needs for referral, because of a lack of available services

Prevention Case Management

(caution: people with prevention needs may not be ready to see themselves as "cases")

advantages/strengths

• can work for people comfortable with coming to a structured environment

• can help to meet the needs of people seeking some stability/regularity in their lives

• can meet the needs of people on the street, if PCM is street-oriented and designed for mobility
• can especially impact people who are reaching an action stage in dealing with health concerns
• can be effective in a health center/hospital, where clients can be drawn in from other departments
• can gain trust in the community if prevention case managers do their own outreach/recruitment

considerations

• may not work as well for people with low perception of their risk for HIV; these people are less likely to seek linkage to services (for housing, financial assistance, etc.) from an HIV/AIDS-identified organization
• fits a middle-class model for support: generally occurs in an office setting, with an atmosphere of clinical distance
• does not necessarily even appeal to a middle-class population at risk, since middle-class people may prefer to go to a therapist or other support system for their prevention needs
• has often had difficulty forging a relationship with the community it intends to serve
• may be more effective when it functions as a **piece** of a comprehensive service system, than when it tries to provide a comprehensive set of services itself.
• requires clients to have some time and appointment-keeping abilities

Counseling, Testing, and Referral

(CTR can be described as universally applicable, with a note that different groups may be reached through anonymous and confidential testing or through different testing venues.) The factors to consider for targeting CTR include:

a) timing
b) venue
c) staff representation of the community
d) accessibility of site
e) mobility of CTR
f) drop-in vs. appointment-based services
g) anonymous vs. confidential services

Note: There is some debate over the most appropriate environment for CTR (e.g., a site created just for HIV CTR or a primary care facility) and the most appropriate kind of provider (e.g., a primary care physician -- doctor or nurse -- or an HIV testing counselor). The primary care context may be more appropriate for communities in which there is more stigma attached to HIV and/or a greater likelihood that people will seek care from a single provider and for general health concerns. It is important, however, to ensure that doctors or nurses providing test results are fully trained to do the counseling and referral work for their clients (training of all CTR providers should be ongoing and central to the program).

advantages/strengths

• can function as a method of HIV prevention; it becomes part of a regimen of health care
• will be most inclusive when a provider offers anonymous **and** confidential forms of CTR
• will be most inclusive when a provider offers both appointment-based and drop-in CTR

considerations

• may have fewer benefits for people in a situation of total isolation and lack of social support
• may have fewer benefits for people in an early stage of recovery from substance abuse (although CTR can become part of the recovery process, if it is done properly and/or the client responds well)

The best way to break down the applicability of CTR may be to talk about **anonymous vs. confidential** CTR as one divider and then look at the **location** of testing as another distinguishing factor.

Anonymous/Confidential:

The ability of an agency to provide anonymous or confidential services depends partly on the record-keeping standards of the agency. Some providers encourage clients to use false names for testing records, allowing for a kind of middle ground between confidentiality and absolute anonymity. It should be possible for a service provider to use client names for some services and still use an anonymous records-keeping system for HIV testing.

advantages/strengths (*confidential*)

°Confidential services expand the possibilities for follow-up and case management of the testing client. With youth and pregnant women, for example, it may make more sense to focus on confidential testing and the capability for referral to services.

advantages/strenths (*anonymous*)

°Anonymous testing serves the needs of clients who fear the repercussions of reporting of their HIV status, or who simply do not want their name on record.

(**Note:** there is some question now as to whether anonymous testing will continue to receive government funding; there is a growing political pressure to get reporting of test results.)

Location:

e.g., a **mobile testing unit** can be effective for targeting clients with low perception of risk in the venues they frequent.

Partner Notification

Partner notification is generally applicable for anyone wishing to inform partners of their positive HIV status. By design, it targets people who are at risk as partners; and it may often be the only means by which people in this group become informed of their risk.

advantages/strengths

• is especially valuable for anyone who wishes to notify a partner who is not currently in their life or who may have a violent or abusive reaction to hearing the news directly from the client

• can be done by the service provider alone, or can be done jointly by the service provider and the client, depending on what is more comfortable and safe for the client

• is always an in-person service, allowing for on-the-spot counseling/referrals

considerations

• can only reach those partners mentioned by the clients who wish to use the service (voluntary)

Needle Exchange

advantages/strengths

• is applicable to IDUs

• can be useful for the transgender community, and for other people who inject steroids or vitamins, as well as for IDUs

• compared with pharmaceutical outlets, needle exchange programs are more appropriate for higher-risk populations, which may require ancillary services and other prevention tools

• can be most effective if they meet the safety needs of IDUs (in terms of both keeping down police presence, so as not to scare away clients, and having a protective, vigilant staff to prevent clients from causing problems for each other)

• a site can be developed specifically to serve the needs of a particular neighborhood

• can provide a bridge to drug treatment when appropriate; this linkage/collaboration of needle exchange and recovery services should extend beyond the giving out of a treatment provider's phone number (it might involve offering passes, which reserve a treatment spot, to interested needle exchange clients)
• may also serve as a bridge to CTRPN services

considerations

• is inappropriate in the context of a 24-hr. residential treatment program, and there is still some question of its appropriateness for clients who are in other kinds of drug treatment programs

Hotline

Hotlines are widely applicable to groups at risk for HIV.

advantages/strengths

• can be especially good for people in crisis and/or people needing basic information and answers
• can be especially useful for groups requiring support and/or anonymity
• do not only provide HIV prevention information and counseling, but can offer linkage/referrals to other services as well.

considerations

• are not appropriate for people who don't have access to telephones (or don't have change, if the hotline is not a toll-free number)
• cannot reach people who don't comfortably speak the language(s) offered

Single Session Group Workshops

advantages/strengths

• can be run as one-time skills-building workshops, especially for those people who have the "KABs" favoring risk reduction, but have not changed behavior
• can be beneficial for groups that cannot commit to multiple sessions (agencies should indicate why their clients cannot commit to multiple sessions)
• can serve as a first step or launching pad for clients' other prevention-oriented activities, if they focus on creating linkages
• can be good for populations at lesser risk that have fairly good information, but want to build awareness and sensitivity (e.g., friends, family, or employers of people with HIV); and can be designed specifically to educate people who might become educators or advocates
• can clarify to people at low risk that they **are** at low risk, and in this way reduce the demands made on testing centers by people who are just worried about HIV in an unspecified way, not having to do with any actual risk behaviors
• are cost-effective, in that they can use one staffperson to address a roomful of clients
• can be provided in mobile vans, as an effective way of accessing higher-risk groups in their venues

considerations

• are less helpful for people with serious mental health issues
• are generally less effective for people who already have a great deal of knowledge, a healthy attitude, and prevention-supporting beliefs regarding HIV
• may also be less beneficial/less feasible for the highest-risk populations and those most in denial (agencies should be required to show the acceptability/ feasibility of the single session group intervention to their target population)

Multiple Session Groups

advantages/strengths

• are most applicable for people with high perception of personal risk

• are most useful for people who are already highly motivated

• are not limited in their feasibility to a middle-class, stable type of population; regular groups may provide a needed/desired structure and container for people otherwise lacking in stability and structure (e.g., some homeless and/or jobless people)

• attract people who perceive themselves to be part of a cultural group or community, and who are seeking connection with others who have shared experience and interests

• may be utilized more fully by women, who tend to take advantage of discussion and support groups and to work well with relational models

• can also make a huge breakthrough and first opportunity for people who are unaccustomed to engaging in group activities or to talking about sexual and drug-related behaviors with their peers

• can draw MSMs (many older and Latino MSMs, for example) who are seeking social contacts and support outside of the gay bar scene

• are especially feasible and easy to integrate when conducted with a captive audience (e.g., youth in schools, clients at in-house treatment centers, and other people in institutional settings)

considerations

• tend to be less helpful to participants if they are didactic rather than interactive

• can encounter difficulty in trying to retain participants for continuing groups

• require a "hook" other than HIV prevention alone, to motivate regular attendance (Note: this is absolutely essential for youth participation)

• may not be feasible for people with limited free time (e.g., people who are struggling to hold onto housing/employment **or** juggling house, kids, education, work, etc.)

Speakers' Bureau

advantages/strengths

• are accessible to people at a low literacy level

• can be helpful for people needing basic information about HIV

• can have an impact on people who don't know anyone with HIV (or think they don't)

• can serve as a denial-breaker for people with low perception of personal or communal risk

• can work well with a captive audience (people in institutional settings like school, jail, etc.)

considerations

• are not as appropriate for people with multiple issues or mental health stressors

• are generally not sufficient as the only intervention done for a group -- should not be done in isolation from other prevention activities

Media

(generally applicable, and can be adjusted to its target audience)

advantages/strengths

• does not require interest or action on the part of the audience -- and so can reach groups with little to no previous awareness or concern about HIV

considerations

• has to consider the stages of change appropriate to its target audiences, and meet the readiness of the audience to receive prevention messages

• mostly provides a backdrop or stage for prevention activities, and is not as useful if it is the only source of prevention information available to someone (personal interactions should take place against the backdrop of media messages, in order for media to have an impact)

Media can be divided into targetable and mass media forms. The difference has to do with the intended audience -- is it a specific target group or is it the general public (or a set of people who do not identify or socialize with a group of others like them, such as *partners*)?

Targetable media

advantages/strengths

°is appropriate for groups which are less likely to seek out or have easy access to HIV-related information (e.g., people who are homeless, IDUs, or lower literacy)

°offers prevention without any economic investment on the part of the audience, and so can reach people who are unable to afford a TV or radio, for example

°can reach people with clearly identifiable "turf" or regular venues for hanging out

°can increase the perception of personal or communal risk among people who, due to denial or some demographic factor, have not seen themselves as being at risk

considerations

°has to be informed by a thorough needs assessment of the target audience, in order to pitch its message at the appropriate stage of change, and hit a nerve emotionally

Mass media

advantages/strengths

°can motivate people on a group/community level

°can be helpful to people who have a low perception of personal or communal risk

considerations

°may not be as effective for groups facing multiple issues and barriers to behavior change

Venue-based Group Outreach

(generally applicable -- with tailoring to the audience. This category includes events/ performances that people attend out of interest and performances done for the unsuspecting.)

advantages/strengths

• can reach people who identify with some community and/or a group scene/social group

• in the form of street theatre, can also reach people who may be in the venue less purposefully, or for reasons having less to do with social/communal identity

• can be structured to address a group with multiple issues and barriers to change

• can provide a forum for dialogue between friends and family (community-building)

• can work for groups with a lack of access to services

• can be helpful to people with a low perception of personal or communal risk

• can be helpful to people needing basic information and referrals

• can serve as a launching pad for other prevention activities (for groups taking a first step toward risk reduction)

• can be useful for groups which have never experienced another intervention

• can address people at various stages of change

considerations

• has to work harder, if attempting to reach people who are closeted, not identified with a group/community, or not already a captive audience (since they are unlikely to come to a prevention-related performance)

• has to create and maintain a safe environment for the targeted audience (needs assessment)

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STRATEGIES AND INTERVENTIONS CHAPTER

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[*] **Key:** Definitions follow each intervention or strategy category. Standards of service provision are indicated by bullets. The expected outcomes follow, in numbered italics.

INTRODUCTION

The intent of our planning effort was to identify, succintly define, and make recommendations around the implementation of HIV prevention strategies and interventions that the Council believes are effective. This information is presented with the explicit understanding that it is a reference and a resource, not a mandate, for prevention planning and program design.

Data for this chapter was gathered from the following sources:

- Results from 1994 focus groups with members of target populations
- Community meetings
- Self-reporting from prevention service providers in interviews, discussions and written reports
- Appropriate published research literature
- Key informant interviews
- Group interviews and discussions among HIV Prevention Planning Council members
- The California State HIV Prevention Plan

The apparently discrete prevention categories are presented as such for the sake of clarity in discussion, and are not meant to suggest that in practice these interventions fit into strictly bounded categories. Also, the Council would like to recognize the complementary nature of these strategies and interventions in the development of comprehensive prevention programs, as successful programs generally employ several strategies and interventions as components to effectively serve their target populations.

RECOMMENDATIONS SPECIFIC TO EACH STRATEGY OR INTERVENTION

The following document details brief definitions, standards for service provision, expected outcomes, and effectiveness data for a range of possible HIV prevention strategies and interventions.

Definition:

The definitions for strategies and interventions strive to create a common language around HIV prevention in San Francisco. The Council would like to encourage and applaud creativity in program design and to acknowledge the fluidity of these definitions, as some interventions may fall between categories outlined here.

Standards for Service Provision:

These are the recommendations of the Council for effective service provision of a particular intervention. The language employed for these recommendations (generally including the word "should") was chosen with the understanding that an intervention may not match all of the standards for service provision and can also exceed them. However, the standards outlined in this document are ones which the Council feels are crucial to effective delivery of prevention services. Any program using a particular intervention should address each of the standards of service provision listed for it, and explain any reasons for diverging from them.

Expected Outcomes:
The expected outcomes are general outcomes the Council feels are reasonable and measurable for a particular strategy or intervention and should be incorporated into the evaluation process of a program using that strategy or intervention.

Effectiveness and Background Information:
This effectiveness data and background information was compiled from the State of California and the City of San Francisco HIV Prevention Plans. It consists mainly of research, theoretical models, and providers' and consumers' testimonies which support each intervention.

GENERAL RECOMMENDATIONS
Alongside the individual intervention categories, a set of general recommendations has been developed for application by all HIV education and prevention providers. The general recommendations were formulated after several themes were identified as operating across intervention categories. These themes included: linkages and coordination, training, volunteer use, prevention messages, needs assessment, evaluation, confidentiality, and grievance/feedback procedures.

Linkages and Coordination:
Prevention programs should share the larger goal of creating a coordinated referral system of social services, by linking issues pertinent to their target populations. Coordination of services enables service consumers to access information, especially around HIV prevention, that they might not otherwise receive, and can be an excellent way for providers to outreach to clients at risk. A preliminary list of social services to prioritize for coordination with prevention includes: substance abuse treatment, immigration services, legal services, general assistance, mental health or primary health care services, shelters for homeless, shelters for battered women and children, rape crisis counseling, child protective services, suicide prevention, job training and placement, youth and runaway services, family planning, STD care and prevention, and services for people with physical, emotional, and/or learning disabilities.

Service Delivery Training:
Training should be mandatory and incorporated into both proposals and contracts. Funding should be available for trainings and conferences, including travel and per diem, as part of quality assurance for prevention services. Without adequate trainings, both clients and staff are at risk for misinformation and, at worst, personal injury. Training should be equally available and provided for volunteers, peer educators, and paid staff. Scheduling constraints should be respected for volunteers and peer educators, who often have to balance their program work with other jobs or with school. For example, it may be necessary to hold some trainings during the evenings and/or weekends, to meet the needs of volunteers and peer educators.

Volunteer Use:
Volunteers should be offered the same training and support opportunities available to regular staff. The expectations an agency has for its volunteers should be clearly delineated at the outset of training, and volunteers should be made aware of the rules and regulations applying to all personnel, in addition to the requirements of them in the area of HIV education and prevention information. Volunteers should be well-supervised for consistent quality control within the agency.

The needs of volunteers as recipients of education and prevention should also be considered and met with appropriate services. Volunteer safety in, for example, street outreach situations should be protected through the use of outreach pairs or teams, or through some other mechanism for supervision. The possible health hazards of the job should be seriously addressed for volunteers who do not have health insurance. Similarly, financial assistance should be considered for any required innoculation, blood testing, and/or stick testing (TB test) of volunteers without health insurance.

Since the volunteer does not have the incentive of pay, other ties and loyalties to the work and the agency should be built and reinforced. Incentives should be considered as a possibility for recruitment and retention of volunteers. Prevention events and services provided to the community at risk should also be considered as possible sites/opportunities for volunteer recruitment.

Prevention Messages:
Prevention messages should be concise, relevant, and appropriate to the target population(s). They should address the target audience member in her/his social/sexual/economic/ geographical/historical/political/philosophical/communal context, and should emphasize the importance of the client's functioning and being treated as a whole person, with a complex realm of interests, needs, and concerns. Prevention messages should raise awareness that HIV does not exist in a vacuum. Some issues that can be productively linked to HIV in prevention messages are: STDs, substance abuse, racism, sexism, homophobia, biphobia, transphobia, immigration, poverty, homelessness, unemployment, youth issues, domestic violence, pregnancy and contraception, health care, mental health stressors, survival sex, rape, suicide, and access to social services. Designing prevention messages in collaboration with members of the target audience is an effective way to get at these kinds of issues with appropriate language and sense of context.

Needs Assessment:
Every intervention should begin with a needs assessment to determine whether or not it will serve a real need in the targeted population/community, to identify relevant issues for that group, to gauge commitment and timing requirements for the intervention to reach its audience, and to measure the feasibility of a proposed intervention within political and contextual constraints. The target population must be allowed a proactive role in this assessment. Needs assessments should bring out the most effective venues and media for prevention work, the conditions of client participation, the levels of need and interest in the community for different intervention types, the degree of risk for HIV faced by a particular community at a particular time, and the kinds of cultural/linguistic competence and organizational capacity necessary for an intervention to take hold.

Evaluation:
Ongoing evaluation processes determine whether the expected outcomes of a program's intervention(s) are being fulfilled. For this reason, organized evaluations are critical to the continuation and development of programs. Documentation of work, data collection, data analysis, and regular reports are among the tasks that must be built into program structure to demonstrate that expected outcomes are being met and to justify continuation. Appropriate staff time and expertise should be allocated to evaluation activities. The completion of evaluation tasks allows contract monitors to identify programs which are not serving their intended purpose in the target population or community of providers, so that funding may be re-distributed among

more promising prevention programs. Likewise, the integration of evaluation tools into program structure may save a program that is failing to meet its expected outcomes, through early diagnosis of gaps in service, which may then be filled within the contract period. When appropriate, evaluations should incorporate client input (from an exit interview or an evaluation form filled out after a session, for example).

Confidentiality:
Any and all personal information that is disclosed to an outreach worker, peer educator, prevention case manager, or other personnel in the context of an intervention or an intake should be kept strictly confidential by the program representative. While the general issues that come up in the course of a counseling session or outreach interaction can be documented and discussed with supervisors or other members of an intervention team, they should not be detailed in such a way as to allow recognition of the particular client by sight or by full name. Peer educators must be trained and prepared for the transition from the usual social interactions with their peers to the bounded relationship required for successful and ethical prevention work.

Maintenance of confidentiality is especially important in providing services to adolescents, who may require assurances of confidentiality before agreeing to trust or receive assistance from providers. It is imperative that program staff and volunteers know the confidentiality law applying to youth and the services they offer, as well as the protocol for handling confidentiality in their agencies. Program rules and legal regulations around confidentiality should be explained clearly to all youth seeking or receiving services. Minors are entitled to confidentiality with respect to any services for which they are legally able to give their own consent.[1]

Feedback and Grievance Procedures:
All intervention programs should formulate, express in writing, and implement feedback and grievance procedures. Feedback is essential to the continued development of interventions and programs, and to monitoring effectiveness. It is important to encourage continuous input from clients and volunteers about their perceptions of the sensitivity of the host agency to its target populations. Formal grievance procedures should also be made available.

STRATEGIES

Strategies, like the general recommendations above, can be applied across interventions and in every kind of HIV education and prevention program. For this reason, they will be set apart from the interventions themselves.

PEER EDUCATION

Peer education involves the recruitment from a targeted population of individuals who are trained in HIV/AIDS (epidemiology, prevention, resources, etc.), peer counseling, outreach, and the issues of population groups which are difficult to reach with HIV information alone. The peer model can draw on established social networks to disseminate information. Peer education can be used in individual, group, and community-level strategies.

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[1] From an Asian AIDS Project document, "A Note on Confidentiality," pp. 10-11.

Host agencies:

- Should have built-in safety and support structures.
- Should provide an incentive for peer leaders/educators.[2]
- Should draw up a contract with the peer leader/educator detailing her/his responsibilities and compensation.
- Should come up with creative ways to make sure peers get adequate training, counseling, and supervision.
- Should ensure adequate wages for paid employee peers.
- Should create mechanisms to insure diversity.
- Should recognize that peer leaders/educators face the same issues that clients face. The difference between a peer leader/educator and a client is that the former has a responsibility to the agency. Protocols around the status of peer leaders/educators in their agencies must be observed.
- Should include forums to increase sensitivity of the host agencies to the issues of their volunteers (through in-services, community panels, etc.).

Peer education interaction:

- Should really be between peers; facilitators or one-on-one peer leaders/educators perceived to be both credible and of the target group are most likely to motivate behavior change, know how to eroticize safer sex, and be able to talk appropriately about sensitive issues.
- Should not only give information but address behavioral change.
- Should be interactive, multi-issue, and life contextual (i.e. address racism, sexism, poverty, and substance use; while promoting knowledge of all risks, sexual or IV-related, for HIV.).
- Should facilitate community-building, through the articulation and documentation of community and individual needs.
- Should implement procedures for collecting data re.: knowledge, intent of behavioral change, number of prevention materials distributed, recipients of prevention materials (by ethnicity, sexual orientation, age, sexual history, etc. of the peer education clients).

Expected Outcomes:

For peer educators (training and maintaining of peers can constitute its own intervention)

1) *In-depth knowledge of HIV transmission and prevention*
2) *Development of community advocacy and self-advocacy skills*
3) *Intent to change or maintain behavior to prevent HIV transmission or reinfection (e.g. safer sex or needle use)*
4) *Recognition of own risk as well as community risk*
5) *Sophistication of knowledge and tools required to teach and peer model for others in the target population*
6) *In-depth knowledge of appropriate resources and services*
7) *Informal referral capability*

[2] The incentive may not have to be material, but may be considered in terms of other benefits to the peer educator/leader (such as the satisfaction of contributing to healthy community norms, or the pleasure of networking and meeting others who share the same concerns and objectives).

For the program

8) Development of health education materials and interventions that are culturally appropriate to the target population

9) Establishment of peer leader/educator and agency as a resource for and part of the community -- cultivation of trust

10) Recruitment of peer educators and small group participants from among the target population(s)

For the target population(s)

11) Destigmatization of HIV and related issues

12) Development of healthier attitudes, such as the perception of personal risk for HIV

13) Referral to appropriate services/agencies

14) Increased awareness of HIV-related events, groups, and resources

15) HIV knowledge development and debunking of misinformation

16) Intent to change or maintain behavior to prevent HIV transmission or reinfection (e.g. safer sex or needle use)

Effectiveness[3]

A. Outcome Effectiveness

Peer-directed interventions may be useful in providing a credible and positive role model for education recipients, and in creating a network of support to encourage self-protective behaviors (DiClemente & Hamilton-Houston, 1989). It has been demonstrated that **positive support from friends, family, and lovers is related to changes in sexual behavior and increased condom use**, and peer interventions strive to mirror this level of empathy and communication (Ibid.). Peer educators, for example, may be effective in teaching gay men, who may have become quite skilled in condom use, to incorporate new skills, such as learning how to initiate frank discussion about HIV status, or reducing the number of sexual partners with whom anal intercourse occurs (McKusick, Hoff, Stall, & Coates, 1992).

Participants in all five focus groups sponsored in conjunction with the state prevention planning process emphasized the importance of receiving information from peers. **Peer education plays an important role in helping people perceive their own personal HIV-related risks.** Perception of personal risk is an important factor in ultimately changing personal risk behavior.

[3] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

Peer educators can positively effect group norms, and peer educators are better able to talk frankly about sensitive issues around sex and drug use. Eroticizing condom use and emphasizing the erotic appeal of safer sex are critical components of interventions designed to change sexual behavior (Catania, et. al., 1991). Peer educators may be better equipped to understand what a particular group may or may not find erotic. "Helpful support from more formal sources (e.g., physicians, psychologists, etc.) was not associated with changes in condom use." (Catania, et. al., 1991).

An evaluation of a program that trained popular people in gay bars to serve as informal peer educators showed a reduction in high-risk behavior. **The results support the utility of norm-changing approaches to reducing HIV risk behavior, accomplished through the use of peer educators** (Kelly, et. al., 1992).

Background -- Peer Education[4]

The importance of peers as educators is based in diffusion of innovation theory. Diffusion theory suggests that information and learning flows through natural social networks; people are more likely to adopt new behaviors if they are introduced by someone who is similar to them and is perceived to be a role model (20, 3). Peers are identified by how you define who you are trying to reach. Therefore peer educators may be similar to the target population by behavior, culture, race, age, ethnicity, gender, or other factors salient to the target population.

Since peer norms appear to be important influences on adolescent behavior, peer education can assist in changing the perception of norms with respect to HIV and risk behaviors (22).

> Research has shown that successful adolescent peer educators "evaluate AIDS information for authenticity, reconstruct it for themselves and their peers, and use their own personal or vicarious experiences as filters through which they interpret and pass along information and advice (16)."
>
> Current research indicates that HIV prevention delivered by peers may be viewed as more credible and sensitive than interventions delivered by local, state, or federal health officials (23).
>
> A study of African American youth in San Francisco, indicates that participants in a peer-led skills training regard peer education as useful and important (16).
>
> A small pre and post-survey of out-of-school youth who participated in group peer education indicated increased level of knowledge and intention to use condoms. This group indicated that they were more likely to ask questions about sex to peer educators than adults (24).
>
> An assessment of the HIV prevention needs of gay and bisexual men of color found that programs that were the most effective for HIV prevention among gay men of color are those run by and for gay men of color (25).

[4] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

NATURAL OPINION LEADERS

Natural opinion leaders are key people who are recognized as influential and charismatic members of a community or communities. For example, peer educators and peer leaders are often volunteers in HIV/AIDS programs throughout the various HIV/AIDS agencies, and may gain a natural opinion leader status. An opinion leader may be viewed as representing her/his community in the entertainment field, in sports, in government or politics, in academia, in business, in popular culture, in community work, and so on.

Training and prerequisites:

- Peer educators and natural opinion leaders should be from the target population.
- Community input should help to determine who will be tapped as a natural opinion leader
- Natural opinion leaders participating in education and prevention efforts should be trained in basic HIV/AIDS/STD knowledge.
- Opinion leaders should be informed about existing resources, services, and approaches for HIV/AIDS education and prevention.

Expected Outcomes:

1) *Acceptance by members of the target audience that HIV/AIDS issues are relevant to their community(ies) and their personal lives*
2) *Increase in receptiveness toward AIDS/HIV-related information*
3) *Destigmatization of HIV/AIDS issues, and loosening of stereotypes of people affected by the epidemic*
4) *Some knowledge development and/or debunking of misinformation*
5) *Increased motivation to participate in HIV prevention activities*

Effectiveness[5]

A. Outcome Effectiveness

No specific information on outcome effectiveness was found. However, there is substantial evidence that after specific announcements of personal HIV status by public figures such as Rock Hudson or Magic Johnson, hotlines and informational outlets become deluged with questions from concerned individuals, usually relating to their own HIV risk behaviors. Certain celebrities clearly have a powerful ability to draw attention to an issue such as HIV, and to prompt people to consider their own personal levels of HIV risk.

As a strategy for preventing HIV infections, however, the usefulness of natural opinion leaders (*e.g.*, Magic Johnson) may be limited. **Natural opinion leaders, due to their high profile and visibility, can be instrumental, however, in increasing awareness and knowledge of HIV/AIDS and related prevention services.**

[5] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

SOCIAL MARKETING

Effectiveness (of community-level interventions in social marketing)[6]

A. Outcome Effectiveness

While there are few studies evaluating the effects of social marketing as an HIV prevention strategy, this educational approach has been widely regarded as being instrumental in helping to change community norms regarding safe sex among gay men in San Francisco in the 1980s. **"Media programs, effectively designed and executed, can change behavior significantly.** The evaluations of the Swiss and French media campaigns have taught us that." (Coates & Stryker, 1994). As Coates & Stryker (1994) note, "We need bold, innovative, and aggressive public health measures to slow the epidemic...We are talking about bold social marketing programs such as those used, with great success, in Africa and Europe....Programs that change community norms are essential for impact effectiveness." Social marketing can be effective at changing community norms.

An evaluation of an intervention for migrant farm workers in San Diego that used fotonovelas and radionovelas to disseminate AIDS prevention information met with notable success. Post-test knowledge scores increased significantly for those groups who were given the prevention material, but not for the comparison group. The data also clearly shows a direct effect of the program on attitudes. In one of the two study locations, the materials resulted in the target behavior change of greater condom use among prostitutes (Conner, 1992).

Background -- Social Marketing and Use of Media[7]

Social marketing involves the production of a message disseminated through a mode that is appropriate and effective for the target population. Social marketing includes the development of a marketing plan, the design of message, use of mass media, consensus building, and packaging (20).

COMMUNITY ORGANIZATION[8]

Effectiveness

A. Outcome Effectiveness

A number of studies have preliminarily indicated that community organization, by involving the entire community in its efforts and by addressing the root causes of HIV-

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[6] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

[7] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

[8] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

related risk behavior, can potentially have dramatic effective on community norms, and can effect a reduction in risky behavior. An exploratory study in San Francisco of Latinos and of non-Latino whites, for example, found that community and family members "revealed a high willingness to provide AIDS prevention advice to drug using friends and family members." Such an approach may be particularly effective among Latinos where there is a high degree of importance place on the family. The literature also indicates that effective community-specific HIV/AIDS prevention strategies should originate from community members themselves, as a way to assure both accessibility and applicability.

The different inter-community environments in which community mobilization messages are presented must vary to reach as many at-risk individuals as possible. In the case of community organization to reach young people engaged in high-risk behavior, an effective mobilization model can be visualized as three interlocking circles, involving, in the case of adolescents, home, school, and the community. Health education projects have been most successful in these model when parents have been involved as an integral component (Ibid).

Background -- Community Organization[9]

Community mobilization and organization involves community-wide efforts which bring together members of the targeted community to address the issue of HIV. Strategies used to bring members of the community together vary according to the needs and characteristics of the target population. The theoretical underpinning of community organization for health behavior change is based in several theories including social learning theory, the health belief model, attitude change theory and diffusion theory (20)

> A community-level approach developed and implemented by peers of the target population was effective in decreasing unprotected anal intercourse relative to those in a control community (21).
>
> Effective organization of the gay and bisexual community in San Francisco in the mid to late 1980s contributed to the dramatic decrease in unprotected anal intercourse that decreased HIV transmission during that period (20).

INTERVENTIONS

A. ONE-ON-ONE INTERVENTIONS

VENUE-BASED (STREET AND COMMUNITY) INDIVIDUAL OUTREACH

Venue-based individual outreach is a one-on-one interaction, preferably with a pair of outreach workers covering the same venue, that may include the distribution of appropriate prevention materials, assessment of a client's needs, provision of health education and risk reduction information and referrals, and dialogue about a client's issues regarding HIV. The success of a venue-based outreach program is critically dependent on the skills of its outreach workers.

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[9] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

Outreach is most effective when it is consistent, continuous, and performed by someone indigenous to the community targeted. As outreach can also be a community-level intervention, it is listed separately in the community-level section of this document.

- Appropriate training is essential to address safety issues (of CHOW and client), referrals (ensuring that the "whole person" is addressed), and policies around field notes (especially their confidentiality and the importance of anonymity of the client).
- Outreach workers should be given some training in the principles of prevention case management (see next section), which can be taken to the streets or other venues (mobile).
- Needs assessment should be done as focus interviews rather than groups, because many people are uncomfortable discussing certain needs in front of their peers.
- Venue-based outreach should take place in a natural or community setting at appropriate times of the day/night, week, and year.
- Outreach workers should establish themselves and the agencies they represent as resources for the community regarding HIV,STDs, substance use, and support for other issues (such as poverty, racism, homophobia, sexism, discrimination based on gender identity, etc.).
- The interaction should support whatever the client's current needs are, whether they indicate the appropriateness of no interaction, of prevention materials only, of basic information, of referrals to or on-the-spot case management, or of counseling on test results, etc.
- *Latex Barrier & Bleach Distribution and Demonstration*
  - Should be the first step of outreach.
  - Should be continuous to reach the constant influx of people.
  - Should be location-specific (e.g. to bars, clinics, hotels, or halfway houses).
  - Should use media, video, and other interactive technology.
  - Can sometimes be suitable as a one-step process, but is generally more valuable as the first of multiple contacts.
  - Can be done as part of street-based prevention case management.
- Information available to clients should deal not only with HIV/AIDS but with injection drug use, other substance use, hormone injection, and/or any other health issues that may be related to client risk.
- Venue-based outreach can be done in a variety of locations: the street, homes, raves, schools, churches, temples, synagogues, mosques, hospitals, sport leagues, gyms, the general assistance (GA) office, single room occupancies (SROs), halfway houses, public housing, laundromats, crack houses, fairs and other community events, massage parlors, porn theaters, community centers, gambling parlors, businesses (like Tower Records), and so on.
- Venue-based outreach can be structured as a one-time intervention or can be part of a long-term relationship established by the CHOW with a client or community.
- When appropriate, should **a)** address continued risk behaviors in the face of HIV knowledge, **b)** follow up on materials distribution, **c)** include referrals, and/or **d)** be conducted as prevention case management for chronic high risk behaviors.
- Should provide outreach documentation and data collection appropriate to the venue. Data collection for outreach and for peer education is necessarily indirect and general, rather than an overt, survey-style data collection. Field notes should be minimal, anonymous (do not unmistakably identify client), confidential, and journal-like in style. Clipboards are generally a barrier to communication (when they do not preclude any communication whatsoever), and especially for recent immigrants and sex workers. However, they have worked in the past with gay men, some sex workers, and some transgendered people on a

limited basis, and when a particular CHOW has established a long-term relationship with a particular community.
- Should perform follow-ups whenever possible.

Expected Outcomes:

For the program

1) Venue/institutional participation and support -- the development of a cooperative relationship with schools, businesses, bars, etc.

2) Establishment of CHOWs and agency as a resource for and part of the community -- cultivation of trust

3) Recruitment of peer educators and participants for small groups, along with general dissemination of information about HIV-related events and resources

For the target population(s)

4) Destigmatization of HIV and related issues

5) Development of healthier attitudes, such as the perception of personal risk for HIV

6) HIV knowledge development and debunking of misinformation

7) Intent to change or maintain behavior to prevent HIV transmission or reinfection (e.g. safer sex or needle use) -- this can be assessed partly by what clients take and what they decline of the materials offered them, how they listen, questions they ask, etc.

8) Referral to appropriate services/agencies

Effectiveness[10]

A. Outcome Effectiveness

Several of the studies discussed the effectiveness of outreach programs and of the core elements that influence that effectiveness. Several studies state that **the most critical factor to effectiveness is the outreach staff themselves.** Staff field workers, as much as pamphlets, condoms, and bleach handed out, need to be considered as intervention strategies in themselves. For an outreach program to be effective, **the staff delivering the intervention needs to be respected, trusted, credible, open, and friendly, dedicated, and non-threatening or judgmental.** Once such trust is established, however, the results can be impressive. In one study of 554 IDUs in San Francisco, almost one quarter (24%) reported learning about bleach use from a community health outreach worker (Watters, et. al., 1990).

"The hardest behavioral change to initiate is safer sexual relations including condom use with main partner." (Watters, et. al., 1990; also others). A study of outreach to sex workers, for

[10] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

example, found that condom use with their clients increased while condom use with personal partners remained inconsistent.

In an analysis of outreach prevention activities in three U.S. cities, Birkel, et. al (1993) offers the following explanation for the poor response to condom promotion: "Overall, the data suggests that **the presence of indigenous outreach workers in the neighborhoods of these three cities created significant reductions in both needle and sex risk behavior**...The intervention appeared to be **least effective in lowering sex risk, particularly among females, and among subjects 25 years and younger...**"

The authors of the above study suggest several reasons why outreach seemed less effective among females and among younger persons. "Perhaps age differences between outreach workers and younger IDUs existed which led to their having less credibility with this group. It may also be that the dynamics of risk among young people are quite different from those in older cohorts and, as a result, may be less affected by street outreach techniques. For example, younger IDUs may be more influenced by group norms and values, and may need to feel that peer group acceptance of certain behaviors exists before adopting. In relation to sex risk, younger IDUs may engage in more spontaneous sexual relations and/or sexual relations following drug use, resulting in less consideration of risk reduction." (Birkel, et. al., 1993).

"A combination of the following reasons may be linked to the lesser reduction of sexual risk that occurred and the continued high rates of unsafe sexual practices among females....1) desire to have children; 2) IDUs surveyed were almost entirely Hispanic-Catholic, and religious beliefs and values that were anti-birth control may undermine the use of contraceptives; 3) culturally based values regarding male sexual behavior; 4) many females feel powerless to protect themselves through insistence on safe sexual practices...." (Birkel, et. al., 1993).

While the availability of condoms, other barriers, and bleach are obviously necessary for the adoption of their use, distribution of these items is not a complete intervention without instruction in their use. Similarly, distributing condoms and other barriers will not be effective if recipients are not motivated to practice safe behaviors. However, **those who receive condoms with accompanying text and/or diagrams have significantly enhanced attitudes toward their use,** while those who receive condoms without any instruction show no significant change in their attitudes toward condoms (Tanner & Pollack, 1988). One study of sexually active inner city junior high school students found that respondents who perceived the cost of condoms in general to be low were 1.9 times more likely to be consistent condom users than those who did not.

Background -- Street and Community Outreach[11]

Street and community-based outreach programs are widely used to reach large groups of people. Outreach workers provide services to persons where they are in their natural settings, and serve as links between programs and communities. In San Francisco, trained community health

[11] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

outreach workers (CHOWs) conduct direct AIDS education, including distribution of condoms, bleach, and educational materials, with community members (7).

- Research and other data show street outreach is successful in communicating prevention messages to many populations and is associated with behavior changes, especially when it involves peer leaders, targets particular communities and reaches them near the location of risky behavior (8,9).

  It is notable that street and community-based outreach services are the only intervention proven in published research to be somewhat successful with youths, one of the most difficult groups to reach with prevention messages (8).

- Research data, focus group participants, key informants and providers all emphasize that outreach services must be appropriate to the target population and its norms (10).

  Clients should be able to identify with outreach workers. For example, research shows using outreach workers from the community contributes to the positive impact of outreach programs targeting IDUs.

  Research has shown that staff who were from the targeted community and population were more likely to gain access to sex workers and became role models for behavior change (3).

- Outreach service providers say consistency in outreach workers is important to the success of outreach programs.

  High turnover among outreach workers is a problem because rapport between the worker and the community is vital to the success of outreach programs.

  Building trust with members of the target population has been found to be an important factor for continued participation of the target population (3).

- Outreach providers also indicate that to be more effective over time, outreach contacts must be repeated regularly or include follow-up support.

PREVENTION CASE MANAGEMENT (PCM)[12]

HIV prevention case management concentrates on providing prevention education and counseling. It also functions to identify, coordinate, and/or deliver appropriate and culturally specific primary and secondary HIV prevention services. While regular case management requires a more exclusive focus on direction to services and practical assistance, prevention case management allows the opportunity to provide more emotional and psychological support. HIV prevention case management provides intensive, individualized support to assist persons in remaining seronegative or reducing the risk for re-infection with HIV and other infectious diseases. The issues with which a prevention case manager works are those that put the client at risk for HIV infection, reinfection, or infection of others. The prevention case manager identifies

[12] Much of the information on PCM comes from correspondence and conversations between Dominic Perez of the Asian AIDS Project and HPPC and Joel Reyna of the National Task Force on AIDS Prevention.

any personal or environmental factors in the client's risk, and then intervenes to reduce those factors, connecting the client to services in the process. However, the prevention case manager continues the relationship with the client **beyond** the referral stage, dealing with mental health concerns like self-esteem and other issues or co-factors that keep the individual at high risk for transmission of the virus. Ideally, PCM builds client self-advocacy skills and assists the client in making a plan for risk reduction in adversity.

Training and internal program standards:

- Training should include the peer support model of listening, being non-judgmental, and showing empathy.
- Training should also incorporate the principles of case management, including client charting, and develop awareness of and orientation with the existing services that can assist the prevention case manager in reducing external risk factors and co-factors.
- To make the peer model effective for PCM, both primary training and ongoing support (including clinical supervision for specific issues like suicide, domestic violence, rejection, substance abuse, rape, and self-esteem) should be provided and made as available to peers as they are to staff.
- Qualifications of a prevention case manager should include familiarity with existing services, knowledge of emotional and practical support methods, skills in risk assessment, and a cultural fit (though not necessarily in all respects) with the targeted population.
- PCM should incorporate stress reduction into the work environment.

Standards of practice:

- A PCM intervention should allow for ongoing identification of additional, specialized training needs, and should be able to fill in the gaps as necessary.
- A prevention case manager should have the flexibility to meet one-on-one with a client at short notice, and for as long as it takes to meet the client's immediate needs for the session.
- A prevention case manager should team up with a program outreach worker(s), to establish recognition, credibility, continuity of services, and trust for the prevention case manager in the target community.
- PCM should be flexible regarding HIV status, primarily to provide continuity for clients if they become seropositive.
- Should provide incentives for recovery.
- Should put out a prevention message that addresses the overall person. To this end, PCM programs should have very strong coordination with auxiliary services (i.e. social services, housing, legal services, general assistance, substance use treatment services, job development, vocational training, mental health programs, domestic violence shelters/services, family planning, child protective services, primary health care, continuing education, English as a Second Language programs, immigration services, transgender services, and youth services around securing appropriate and quality care and treatment).
- Prevention case managers can, when necessary, refer a client to a case manager for greater service linkage.
- Should conduct regular case file evaluations, as well as implement anonymous client evaluation surveys to review PCM effectiveness.

Expected Outcomes:

1) *HIV knowledge development and debunking of misinformation*
2) *Intent to change or maintain behavior to prevent HIV transmission or reinfection (e.g safer sex or needle use)*

3) *Increased support to client for safer sex and responsible decision-making*
4) *Contribution to the development of community norms favoring safer sexual and drug-related practices*
5) *Linkage and access to much-needed services that improve the quality of life*

Effectiveness[13]

A. Outcome Effectiveness

Because prevention case management is a relatively new concept in HIV prevention, there are no formal evaluations to which to refer. There are, however, many reasons to believe that it could act as an effective strategy. Extensive evidence supports, for example, comprehensive and intensive prevention programs, and prevention case management is able to assist an individual to address all of the potential risk factors that can lead to unsafe behavior.

In addition, personal efficacy is one of the strongest predictors of low sexual risk-taking (Stall, Coates, & Hoff, 1988). Personal efficacy can be built through prevention case management.

COUNSELING, TESTING, REFERRAL, AND PARTNER NOTIFICATION (CTRPN)

General CTRPN Standards of Service Provision

NOTE: All CTRPN

Training and internal program standards:

- There are different CTRPN activities at medical sites than at community-based sites -- medical sites should be client-oriented, and should focus on individual's status and information about the disease; whereas community-based services should include the above *and* connect clients to available resources.
- Staff/volunteers should be trained in issues of adolescents.
- Staff/volunteers should be educated about counseling and testing and outreach.
- Secretary/clerk of organization should be trained, too, so that everybody has knowledge of counseling and testing and access to testing issues.
- Programs should strive to educate people outside of HIV services about counseling and testing (parks and recreation, pregnancy prevention service personnel).
- Health care professionals should be given some training as mental health service providers.
- Programs should require counselors to experience counseling and testing for themselves.

Standards of practice:

- Case-finding should be built into CTRPN programs.
- Counseling and testing should be a bridge to care as appropriate -- should fit into the continuum of care from prevention to health services.

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[13] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

- Should acknowledge substance use, housing issues, joblessness, etc. as possible barriers to HIV prevention; and should provide linkages to services for housing, substance treatment, jobs, etc.
- Counselors should be able to demonstrate that they understand how the target population is affected by other (non-HIV-specific) issues, and should address those issues to some degree, whether by referrals or otherwise.

PRE-TEST COUNSELING/RISK ASSESSMENT

Pre-test counseling consists of a (usually one-on-one) meeting of the client with a trained counselor. It includes the assessment of person's risk for referral purposes, but also for the purpose of determining appropriateness of testing. Information is provided to the client based on her/his needs. Counseling and testing services can be either anonymous, where the client never gives a real name, social security number, phone number, or address to be filed; or confidential, where the client is guaranteed that her/his identity as a client will never become accessible to anyone outside of the immediate clinic or testing site.

- Counselors should take the following steps in each session:
  - Build rapport and trust to the extent possible.
  - Understand motivation of person to be tested.
  - Understand coping strategies to deal with results.
  - Assess client's support network in life at the time s/he is waiting for results.
  - Clarify meaning of test - confirm that client understands the difference between positive and negative results.
  - Perform standard risk assessment.
  - Give support for risk reduction -- provide health education and promotion.
  - Explain the window period during which testing cannot provide reliable results.
  - Assess need for 2nd pre-test counseling before test (based on coping skills, etc.).
  - Make sure that clients understand that a positive test result doesn't mean they are going to die -- educate about good quality of life, treatment for prevention of certain problems.
  - Make referrals according to where a client leans: holistic, western, etc.
  - Give enough information for clients to make their best choices, and understand the client may still have issues of distrust.
  - Make known the counselor's availability for ongoing training and support.

Expected Outcomes:

POST-TEST COUNSELING/DISCLOSURE

Post-test sessions focus on giving clients their HIV result, but also include provision of risk reduction counseling and referrals, and assistance with obtaining medical or other care. The primary purposes of post-test counseling are reinforcing perception of risk, helping those with a negative result initiate and sustain behavior change, arranging access to necessary medical, prevention, and case management services for people with positive test results; and supporting HIV positive clients in referring sexual or needle sharing partners for testing.

- When people have negative results, this should be used as an occasion to give health education.
- Should assess where the client is in the process of reducing the risk of HIV transmission.
- When possible/appropriate, a prevention case manager should be available on site.
- Should leave client with a phone number to call with more questions.

- All agencies that provide CTRPN should fit into a continuum of service provision so that referral of clients for further care is streamlined.

Expected outcomes:

1) *Client will know result of HIV test.*
2) *Client with a negative result will develop a relevant risk reduction plan.*
3) *Clients with a positive result will leave with at least one referral for medical, preventive, and/or psychosocial services.*
4) *Client with a negative result will know where to go for relevant services.*

REFERRALS

Referrals provide individuals with resources appropriate to their particular needs at that time.

Training and preparation standards:

- Counselor should know that the referral is current, accurate, user-friendly, and sensitive to the needs of that particular person.
- Training of counselors should include counselor going to the referral site; counselors should know the people at the referral site and understand the system; they should know what will happen when client arrives there.

Standards of practice:

- Counselor should call and make the first appointment, then follow up to see if the person goes.
- Counselor should especially provide clear referrals for high risk negatives and for HIV positive people.
- Need for referral should be assessed during pre-test counseling.
- Should offer one or two referrals at a time -- not overwhelm client by giving out a huge packet.
- The special needs of youth should be considered. While a youth's own consent is sufficient to gain services around **a)** pregnancy, **b)** contagious diseases, **c)** rape/sexual assault, **d)** drug/alcohol problems, **e)** mental health problems, **f)** AIDS/HIV (with an age limit of 12 or older for **b, d, e,** and **f** and none for **a** and **c**); there is still a question as to whether service providers will be comfortable serving them and will be aware of their particular issues. Such issues may include developmental issues, child sexual and/or physical abuse, neglect, abandonment, living without families, or having dysfunctional family and social lives.
- Should tell the advantages/disadvantages of referral sites.
- All referrals should be sensitive to issues of age, race/ethnicity, gender, sexual orientation, etc.
- Should provide copy of risk assessment to client.
- Program should standardize demographic forms in triplicate so that clients can take the information with them to referral agencies.

Expected Outcomes:

1) *Client will access additional services*
2) *Anxiety reduction -- enabling action on the part of the client, helping her/him to regain control of her/his life*

PARTNER NOTIFICATION (PN)

Partner notification is a traditional control intervention used in fighting sexually transmitted diseases. It involves public health officials taking responsibility for locating and notifying the sexual partners of people who have tested positive for HIV.

Training and preparation standards:

- Should be performed by public health disease control specialists that routinely provide STD PN. They can add HIV to the STDs for which they do PN.
- Should stress the voluntary nature of clients' acceptance of this service.
- PN service providers should especially be trained in and held to client confidentiality.

Standards of practice:

- Should take an active approach to prevention.
- Should be offered city-wide.
- Counselors should offer PN to all clients.
- PN should include counseling, education about HIV/AIDS that touches on the following:
  - HIV 101
  - Incubation/window period
  - Risk assessment/plan for risk reduction
  - Referrals to testing
  - Condom and dental dam distribution, demonstration
- PN service should be provided in Spanish, Tagolog, Cantonese, Vietnamese, Mien, Hmong, Mandarin, and all other languages that might be spoken by partners of HIV-positive clients.
- PN services should also be provided some evenings and weekends

Expected Outcome: *1)All partners will receive knowledge that they may have been exposed to HIV and will seek determination of HIV status if status is unknown.*

Effectiveness (of HIV antibody counseling and testing)[14]

A. Outcome Effectiveness

The effectiveness of HIV counseling and testing of behavior change has been examined for several populations, mainly to inform the debate about the value of public and privately-supported wide-scale testing programs. Higgins, et. al. (1991) compiled and compared a group of studies, and her findings are presented here. **The findings support the assertion that while HIV counseling and testing programs are important, they should not necessarily be the center of HIV prevention efforts (e.g., Coates & Stryker, 1991).**

The central question pertains to the usefulness of HIV testing in initiating safer sexual and needle-related behaviors. One study (Stall, Coates, & Hoff, 1988) found that neither, "...receiving advice from a physician about AIDS, testing for HIV antibodies, nor counseling at an alternative test site was associated with participation in safe sex."

[14] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

For gay and bisexual men, changes in risk-taking behavior as a result of the test were similar for those aware and those unaware of their antibody status, suggesting that behavior change was not a direct result of testing. Although there were significant declines in risky sexual behavior, there was found no association between risk reduction and knowledge of serostatus or actual serostatus. On the other hand, some studies showed that seropositive men made greater reductions in risk behavior than either seronegative men or men unaware of their serostatus, suggesting that, **for gay and bisexual men, learning that one is HIV-positive may have an impact on behavior.** It is difficult to draw firm conclusions about the impact of HIV testing on risk behavior through the actions of this group (Higgins, et. al., 1991).

Four of ten studies conducted on injection drug users (IDUs) showed no significant differences between groups aware and unaware of their HIV antibody status with regard to needle hygiene, frequency of using a needle exchange program, or sexual risk reduction. Two of 10 studies with comparison groups reported improved needle hygiene behavior regardless of serostatus. **Several studies show improvement in needle use behaviors and reduction in sexual risk taking behavior among IDUs receiving counseling and testing within the context of a drug treatment program.** Such behavior changes, however, were not dependent upon learning one's own HIV serostatus (Higgins, et. al., 1991).

In the case of women who learn of their HIV status while pregnant, studies suggest that HIV testing and counseling does not have an impact on the decision to terminate pregnancy, and **all studies that include pregnancy data suggest that counseling and testing does not have a significant impact on this individual variable.** However, among female sex industry workers, **a study of prostitutes showed an increase in condom use and reduction in participation in anal sex following the receipt of HIV counseling and testing** (Higgins, et. al., 1991).

Among other individuals who engage in heterosexual sex, **studies of HIV-discordant couples** (couples in which one partner is HIV-positive and the other is HIV-negative) **uniformly show that HIV counseling and testing interventions were all followed by reductions in unprotected sex, and by increases in condom use and safer sex behavior** at six-monthly follow-up. **One study of STD clinic users indicated no meaningful difference in the risk taking behavior or those tested and those not tested** following the testing experience. Variations in these studies make them extremely difficult to categorize or to compare, however, and results overall are decidedly mixed (Higgins, et. al., 1991).

Most of the studies cited in Higgins report do not examine the effect of counseling but rather examine the effect of HIV testing or knowledge of serostatus. Many of the studies make no reference to whether the individuals received any counseling or if they did to what extent. A more thorough examination of the studies cited reveal that even those studies that did provide counseling vary from viewing a video to a didactic lecture format to extensive counseling. When studies are viewed in this context, it appears that when HIV counseling and testing affects behavior change it is because it is provided in a manner consistent with the recommendations provided by the Centers for Disease Control on "appropriate" counseling.

B. Cost Effectiveness

One analysis conducted by David Holtgrave (1993), which utilized standard methods for cost-benefit analysis from a societal perspective (as opposed to a client or other viewpoint) found a benefit-cost ratio in HIV antibody testing of 20.09. This finding was based on several major

assumptions used in the base-case analysis, including: 1) the assumption that without public funding, counseling, testing, referral, and partner notification (CTRPN) programs would not be provided; 2) the assumption that for every 100 HIV-seropositive persons identified and reached by CTRPN services, at least 20 new HIV infections are averted; and 3) the assumption that for every $100 spent of direct and indirect costs of CTRPN services, an additional $60 is spent on the ancillary costs of alerting people to HIV issues and to CTRPN availability. Additional benefits due to CTRPN services were ignored for the sake of model simplicity, such as the role of CTRPN in protecting the nation's blood supply; delayed morbidity and mortality due to early intervention; and the likelihood that HIV counseling provides an overall net reduction in risk for those who are found to be negative.

Sensitivity analysis showed that the benefit-cost ratio is greater than 1 for all considered cases. Such analysis indicated, for example, that it is important for persons who test negative to continue to be thoroughly counseled about HIV risk reduction and about maintenance of low-risk behavior. **Holtgrave's analysis strongly suggests that publicly funded CTRPN services result in a net economic gain to society.** However, other research is necessary in order to determine whether, and to what degree, knowledge of HIV-negative serostatus may result in a small, net increase in risky behavior, as has been suggested by some investigators.

Another study (Nahmias & Feinstein, 1990), which, like the above, suggests that counseling and testing is only effective for individuals engaging in high-risk behaviors who change behaviors as a result of testing, arrives at a different conclusion. When looking at the cost-effectiveness of screening the general population for HIV, the study found that the cost of detection varies inversely with the prevalence rate, and that the exact relationship is hyperbolic. For example, when the prevalence rate is one in 20, the cost per detected case is approximately $750; when the prevalence rate is one in ten the cost is approximately $400; and when the prevalence rate is one in four, the cost is approximately $200. A program in Illinois that mandated prenuptial HIV screening, for example, detected 26 cases of HIV infection out of 155,458 total persons tested. The cost of detecting a single HIV infection in this population was thus at least $208,000. **Screening programs applied to persons engaging in high-risk activities would be more likely to be cost-effective.**

On the other hand, it should also be noted that a focus group of HIV-positive women conducted as part of this planning process found that approximately half of the women participants had not been aware when they took the HIV antibody test that they were at any risk for HIV infection. Testing of these women would not have been considered cost-effective, yet clearly they had much to gain from taking an HIV antibody test.

Background -- Counseling, Testing, Referral, and Partner Notification[15]

HIV counseling, testing, referral, and partner notification services provide an opportunity for people to learn about their serostatus, receive prevention counseling, referrals and information relevant to their needs, and receive assistance in notifying partners (11).

[15] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

Counseling and testing play a prominent role in prevention programs. Recently, however, researchers have noted that "counseling and testing are not up to the task of behavior change and should never have been the centerpiece of HIV prevention programs. Counseling and testing certainly have a place, but not the central place in HIV prevention." (10)

- Some research suggests counseling and testing programs have not resulted in significant behavioral change. Yet other research has shown that counseling and testing was fairly effective in reducing high risk behavior in the gay population specifically (12).

  Among drug users that were tested for HIV, improved self-efficacy to avoid HIV infection was associated with learning that one was HIV negative (13).

- Prevention providers, however, say counseling and testing services can motivate individuals to recognize their risk, ask questions about safer sex in a safe environment, and formulate personal risk reduction plans.

  Prevention providers also say they are able to identify new target populations through counseling and testing programs. They note that demand for testing is large.

  The CDC has adopted a new model for counseling and testing based on client-centered behavior changes. Although it is too early to evaluate the model, it might increase the effectiveness of counseling and testing programs.

NEEDLE EXCHANGE PROGRAMS

Needle exchange programs are those that provide sterile needles to injection drug users, and hormone, steroid, vitamin, and insulin users. Needle exchange programs are community or street-based.

Training and internal program standards:

- Sites should be adequately staffed. This includes staff for volunteer coordination, provision of materials, and other elements of the program.
- Incentives should be provided so that volunteers continue to play important role.
- Volunteers should be integrated into all activities of needle exchange.
- There should be a standard volunteer training manual which covers all duties of the job and addresses safety issues, harm reduction theory, infection control/universal precautions, and violence prevention.
- Community based organizations could adopt a site to get credit (units of service) for providing prevention education at needle exchange sites.
- There should be a health education and referral and resource person designated at each site.

Standards of practice:

- Health education messages should be simple, clear, concise, and consistent.
- Referrals should be offered, but based on request of client.
- Condoms, dental dams, and information on safer sexual behavior must be available.

Expected Outcomes:

1) *Individuals will exchange used syringes for clean syringes.*
2) *Individuals will have referrals for services requested.*

3) *Participants will know the time, day, and location of needle exchange services.*
4) *Individuals will know how HIV is transmitted through needle use and through sexual behavior.*
5) *Condoms?*

Effectiveness[16]

A. Outcome Effectiveness

An extensive evaluation of needle exchange programs has been conducted and described. **The majority of studies demonstrate decreased rates of HIV drug risk behavior through needle exchange, but not sex risk behavior. Available quantitative data do not provide evidence that NEPs change overall community levels of drug use** (Lurie & Reingold, 1993). There is also evidence to suggest that laws restricting access to syringes can potentially increase HIV infection rates.

The U.S. General Accounting Office (GAO) examined studies of nine needle exchange programs that had published results assessing the impact of their NEP interventions. According to the GAO, "Only three of these had findings based on strong evidence. **Two of these three reported a reduction in needle sharing while a third reported an increase.**" (United States General Accounting Office, 1993)

Meanwhile, seven of the nine projects examined by the GAO looked at whether NEPs led to increased injection drug use. Five had strong evidence to report on these outcomes, and according to the GAO, "All five found that **drug use did not increase among drug users; four reported no increase in frequency of injection; and one found no increase in the prevalence of use.**" (United States General Accounting Office, 1993). The GAO also found that the forecasting model developed at Yale University was sound and credible. "The model **estimates a 33 percent reduction in new HIV infections among New Haven, CT needle exchange program participants over 1 year.**" (United States General Accounting Office, 1993).

In summary, the GAO noted that, "Data from several projects support the view that needle exchange programs are reaching injection drug users and referring them to drug treatment or other health services." That is, NEPs assist injection drug users in obtaining services that may address core issues behind their risk behavior. However, although NEPs make referrals, there are not always available slots in drug treatment programs to accommodate them (United States General Accounting Office, 1993).

B. Cost Effectiveness

California Planning Working Group (CPWG) member James Kahn, Ph.D. of UCSF has examined models for determining the cost-effectiveness of NEPs using different models and various assumptions. He found that **in almost all cases the cost per HIV infection averted is far below the $119,000 lifetime cost of treating an HIV-infected person. Estimates range**

[16] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

from $3,773 to $12,000. (Lurie & Reingold, 1993). The median annual budget of U.S. and Canadian needle exchange programs is relatively low, at $169,000, equal to the cost of about 60 methadone maintenance slots per year (Ibid.)

Background -- Needle Exchange[17]

- Needle exchange programs are among the most effective interventions for HIV prevention (10, 14).

  Many studies have reported that needle exchange programs have played a significant role in lowering rates of needle sharing and have served as sources of referrals for drug treatment and other services (6, 14).

  Published research suggests needle exchange programs can reduce high risk drug behaviors, although the impact of needle exchange programs on sex behaviors is unclear (1, 6).

  Many IDU focus group participants say they regularly exchange needles. In addition to preventing new HIV infections, IDU focus group participants credit needle exchange programs with providing them access information about other services such as detox programs.

- Initial results indicate that needle exchange programs are cost effective.

  Mathematical models of needle exchange programs "suggest that needle exchange programs can prevent significant numbers of infections among clients of the programs, their drug and sex partners, and their offspring. In almost all cases, the cost per HIV infection averted is far below the ... lifetime cost of treating an HIV-infected person" (6).

- A variety of factors may limit the effectiveness of needle exchange programs, including a lack of resources and of information in target communities about existing services.

  Providers note that overall only a fraction of IDUs use needle exchanges. And IDUs who would utilize needle exchange programs do not always know how to access them. For example, some IDU focus group participants in the Tenderloin are not aware of the schedule for needle exchanges and do not realize the service is available in their general neighborhood almost daily.

- Providers note that IDUs do not always consider needle exchange sites to be safe.

  Providers say IDUs fear that law enforcement officials or social service authorities will intercept them at needle exchange sites. Providers also say that some women IDUs fear their children will be taken from them if they participate in needle exchange programs.

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[17] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

HOTLINE

A hotline is a confidential phone service functioning as an education/referral/help line for anonymous callers. Hotlines offer up-to-the-minute information on HIV and related issues, crisis intervention and counseling, and direction to other social services, as appropriate to client need. Hotlines have the advantages of targeting a wider geographical area than most interventions and being able to reach a greater, more diverse, and sometimes isolated population.

Training and preparation:

- Should provide ongoing training for hotline operators in HIV, crisis intervention, substance use issues, legal issues, abuse counseling for child abuse, sexual abuse, incest, battering, and emotional abuse; STDs, and cultural competence (among other areas).
- Should have culturally diverse, representative, and competent staff.

Standards of practice:

- Should put out consistent prevention messages.
- Should offer all languages appropriate to the targeted population. At least one city-wide hotline for each city should have the capacity to meet the language needs of all immigrant populations in the area (i.e. Vietnamese, Thai, Laotian, Cambodian, Mandarin, Russian, Arabic dialects, Pashtu, and Farsi). Hotlines should have access to translators on an emergency basis as well.
- Should provide brief call documentation (records of call content and the demographic positioning of callers, for example) whenever realistic and appropriate.
- Should have a well-developed system of referrals
- Should promote and reinforce help-seeking behaviors

Expected Outcomes:

1) *Linkage of callers to various agencies/resources, including but not limited to those dealing with HIV*
2) *Knowledge development and debunking of misinformation*
3) *Risk assessment*
4) *Crisis intervention*
5) *Anxiety reduction -- enabling action on the part of the caller, helping her/him to regain control of her/his life*

Effectiveness[18]

A. Outcome Effectiveness

While hotlines may have limited usefulness in directly promoting behavior change (and indeed, as mentioned earlier, this is not their principal stated purpose), they are very useful in disseminating information, particularly to people who are geographically isolated, and to people who might otherwise not seek services. Hotlines are often a first link to other prevention and care services, and are a useful informational and supportive access point to individuals in crisis or with questions, such as individuals who have just learned of a friend or relative's HIV status and does not know where to turn for HIV-related information or support. And while studies show

[18] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

that, although knowledge is not sufficient to cause behavior change, it is a necessary basis for behavior change to take place (Stall, Coates, & Hoff, 1988).

While no formal studies of hotlines were found, a survey of repeat callers to the Southern California AIDS Hotline indicated that the hotline was effective as a prevention strategy. Fifty percent of callers reported that they had increased their practice of safer sex, and 37% reported no change in their practice of safer sex. For 72% of all callers, the hotline had been the only source of HIV/AIDS information since their last call (AIDS Project Los Angeles, 1993).

B. Cost Effectiveness

Hotlines are rarely inexpensive to run and maintain, particularly when they exist to serve wide geographic regions. On the other hand, their per unit cost is low, largely because volunteers are most often utilized to provide the actual answering of phone lines. While the direct impact of hotlines on averting new HIV infections is uncertain, they are probably cost effective even if they avert only a few infections.

Background -- Hotline[19]

Hotlines are toll-free anonymous lines staffed by volunteers who provide education, referrals, support and risk assessment to callers.

> A study of repeat callers to an HIV/AIDS hotline whose only source of HIV/AIDS information was the hotline reported an increase in the practice of safe sex. This included increase in use of condoms and abstinence from sex (15)

B. SMALL GROUP INTERVENTIONS

SINGLE SESSION GROUP WORKSHOPS

A single session group workshop consists of a one-time, intensive session/gathering focusing on information about HIV (e.g. transmission and behavior change), motivational activities, and skills-building. It may also touch on other relevant issues.

- When appropriate, should be a referral/resource made known to clients during outreach.
- Should be facilitated by a trained facilitator or professional, selected also for her/his cultural competence
- Should be planned or requested, and advertised/promoted.
- Should have an evaluation component that is completed by workshop participants.
- Should have ground rules created and adopted by participants.
- Should not be information-based for an information-saturated population.
- Should be interactive.
- Should attempt to provide incentives (meals, food vouchers, etc.) appropriate to the workshop and the target population -- especially important for hard-to-reach groups.
- Should include skills training.
- Should draw people in with other (not directly HIV-related) activities.

[19] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

- Should include hands-on activities (such as role plays).
- Should focus on behavioral change.
- Can involve impromptu groups, vans as session sites, and before/after bar groups.
- Should have counselors available for follow-up.
- Should serve as a basis for further referral.
- Should provide additional support, follow-up groups, and/or "booster" groups.
- Should be multi-issue (e.g. address racism and enact community building).

Expected Outcomes:

1) *HIV knowledge development and debunking of misinformation*
2) *Knowledge of services/community resources*
3) *Intent to change or maintain behavior to prevent HIV transmission or reinfection (e.g. safer sex or needle use)*
4) *Development of skills for risk reduction (e.g. negotiation skills or practical application of latex barriers) that are relevant to the target population*
5) *Increased motivation to participate in HIV prevention activities*

Effectiveness[20]

A. Outcome Effectiveness

There are many studies evaluating the effectiveness of group presentations as an HIV prevention strategy. **Presentations that emphasize skills for behavior change and that are more interactive are more effective than those that simply rely on the didactic transfer of information.** The effectiveness of the didactic transfer method for information is still uncertain. Some studies say it does effect behavior, while others claim that it does not. It is safe to say, however, that basic information on HIV transmission and prevention is an essential element for changing behavior.

A study of African American/Black male adolescents from Philadelphia found that a one-time, five-hour intervention designed to increase AIDS-related knowledge and weaken problematic attitudes toward risky sexual behavior was effective. Compared to a control group, at a three-month follow-up assessment, the intervention group had higher AIDS knowledge, weaker intentions to engage in unsafe sexual activity, and reported engaging in less risky sexual behavior in the three months following the intervention. "Adolescents who received the AIDS intervention were less likely to engage in sexual activities, and those who did were more likely to engage in safer sexual activity." (Jemmott, Jemmott, Fong, 1992).

Conversely, "Calabrese, Harris, & Easely (1987)...found that neither attendance at a safe sex lecture, reading a safe sex brochure, receiving advice from a physician about AIDS, testing for HIV antibodies, nor counseling at an alternative test site were associated with participation in safe sex." (Stall, Coates, & Hoff, 1988).

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[20] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

Two one-day peer-led interventions for gay and bisexual men in Philadelphia were evaluated. Intervention I, a small group AIDS 101-type lecture was less effective in increasing condom use than Intervention II, which included skills training utilizing role play and group process. Although Intervention II was more effective, both interventions increased condom use for insertive anal sex, but neither had an effect on receptive anal sex (Valdiserri, et. al., 1989).

A project in Los Angeles that used peer leaders for 4 to 15 gay and bisexual men in groups lasting several hours found that subjects "improved in terms of knowledge, attitudes, and behavioral intentions." (Institute for Policy Studies, 1993).

A didactic slide/tape presentation to Vietnamese women, led by a Vietnamese nurse at a Women, Infants, and Children health program in Los Angeles, was successful at increasing knowledge and positively influencing intended practices (Flaskerud & Nyamathi, 1988).

Background -- Small Group (Single Session) Interventions[21]

Small group-based interventions can be single or multiple session groups where education, information, social support, and referrals are provided.

- Small group discussion format has been shown to be effective in promoting safer sexual behaviors and intentions among young urban African American crack cocaine users (16)

- Group counseling interventions effectively increase knowledge about HIV and AIDS and decrease high-risk behavior, according to published research (1,17).

  For example, a study of predominantly white, college-educated gay men found that a program of sex negotiation skills training, stress reduction training, intensive group counseling, and information to eroticize safer sex materials modified risk behavior on a short-term basis (17).

- According to service providers, multi-session group interventions have a greater impact on participants than single-session interventions.

  Providers note, however, that single-session interventions are also effective and give access to members of target populations who would not attend multi-session programs. Group interventions are more effective when they address other social or personal issues such as racism, domestic violence or poverty, providers say.

MULTIPLE SESSION GROUP WORKSHOPS

Mutiple session group workshops are a series of workshops/groups/meetings introducing HIV issues and linking them to other life issues not as easily or immediately understood as relating to HIV. They may be closed or drop-in, mixed or serostatus-specific, structured or need/issue-driven groups for risk reduction and psychosocial support. Multiple sessions provide an opportunity to go into greater depth on HIV risk reduction issues and strategies.

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[21] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

- Should be able to examine community issues not necessarily directly related to HIV -- like substance use, youth issues, abuse survivorship, etc. -- and should continually identify additional community needs and issues to be addressed.
- Should be able to continue in the form of several ongoing "splinter" groups, working on specific topics relevant to participants.
- Should be conducted at convenient and safe locations and times for the target population.
- Should be developmental, with topics building on each other.
- Should involve interested community organizations.
- Should incorporate practical, useful skills building based on needs of the target population.
- When appropriate, should be a referral/resource made known to clients during outreach.
- Should be facilitated by a trained facilitator or professional, selected also for her/his cultural competence.
- Should be planned or requested, and advertised/promoted.
- Should have an evaluation component that is completed by workshop participants.
- Should have ground rules created and adopted by participants.
- Should be interactive.
- Should attempt to provide incentives (meals, food vouchers, etc.) appropriate to the workshop and the target population -- especially important for hard-to-reach groups.
- Should draw people in with other (not directly HIV-related) activities.
- Should include hands-on activities (such as role plays).
- Should focus on behavioral change.
- Can involve impromptu groups, vans as session sites, and before/after bar groups.
- Should have counselors available for follow-up (especially at six months, to evaluate the adoption and/or maintenance of safer behaviors).
- Should serve as a basis for further referral.
- Should provide additional support, follow-up groups, and/or "booster" groups.
- Should be multi-issue (e.g. address racism and enact community building).

Expected Outcomes:

1) *Extensive knowledge of HIV/STDs*
2) *Extensive knowledge of services/community resources*
3) *Intent to change or maintain behavior to prevent HIV transmission or reinfection (e.g. safer sex or needle use)*
4) *Healthier attitudes, such as perception of personal risk for HIV*
5) *Development of skills for risk reduction (e.g. negotiation skills) that are relevant to the target population*
6) *Increased motivation to participate in HIV prevention activities*

Effectiveness[22]

A. Outcome Effectiveness

[22] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

There is much data suggesting that multi-session groups can be very effective at changing the risk behavior of group participants, and certainly at changing their level of knowledge. Multiple sessions have a greater possibility of effecting consistent behavior changes than one-time interventions. They also have more potential to deal with the underlying causes of unsafe behavior. Multiple session groups, however, can only be as effective as the facilitator or teacher who leads them. A facilitator or teacher who is not trained in AIDS education, or is not comfortable speaking frankly about sexuality and drug use, cannot lead an effective HIV prevention program.

A study of a two-session classroom AIDS education program involving seventh and tenth grade classes in Rhode Island showed positive results. "Following instruction, students reported more knowledge, greater tolerance of AIDS patients, and more hesitancy toward high-risk behaviors, but the changes were modest....Data lends support to the potential usefulness of school-based education programs, especially if behavior and coping skills are emphasized in the education (Brown, Fritz, & Barone, 1989). Similar results were found in a school-based AIDS prevention program presented in an inner-city school in Northern California serving predominately African American/Black and Asian students. In this population, however, changes in high-risk behaviors could not be detected, perhaps due to the small number of sexually active students (Siege, et. al., in press).

A study of an open-enrollment, pass/fail course at UCLA in 1988 showed positive impact on students' AIDS-related knowledge, attitudes, and behaviors. Compared to a control group, the students who took the lecture course changed their attitudes about critical public policy issues (e.g., mandatory HIV testing) to be in line with current public health policy. "The nature of the effect was to bring students toward greater appreciation of 'individual rights'". "Students were not likely to carry and use condoms subsequent to participation in the course. Conversely, through not statistically significant, students in the class were also perhaps less likely to engage in unprotected vaginal sex." (Abramson, Seckler, Berk, & Cloud, 1989).

An evaluation of an AIDS intervention program at a shelter for homeless adolescents in New York demonstrated significant increases in condom use and decreases in risky behavior. The intervention had no effect on abstinence. The intervention focused on skills training, behavior self-management, and group and social support from peers (Borus-Rotherman, et. al., 1991).

Background -- Small Group (Multiple Session) Interventions[23]

Multiple session groups are structured groups which provide HIV/AIDS/STD prevention information and skill building but often include other topics related to prevention, such as self-esteem and other psychosocial issues.

> A study of African American gay and bisexual men in San Francisco demonstrated that men who participated in multiple session groups had higher levels of behavior change, and maintained behavior change over time than those who attended single sessions groups (18).

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[23] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

An evaluation of a six-session skill-building intervention conducted with high school students demonstrated that this approach was effective in increasing STD and AIDS knowledge and increasing skills to prevent risky sexual behaviors, but not drug use behaviors (19).

C. COMMUNITY LEVEL INTERVENTIONS

Community based approaches to behavior change provide information and skills to change behavior and encourage a supportive social environment through channels and methods that are indigenous to the community. Community-level efforts are also designed to create structures and systems which assist in the maintenance of healthy behaviors. These interventions are based on several theories including social learning theory, the health belief model, attitude change theory and diffusion theory (20)[24]

SPEAKERS' BUREAUS

Speakers' bureaus bring together individuals who have been impacted by the HIV epidemic, to speak to groups of people, communities, or organizations. Participants of a speakers' bureau could include, but are not limited to, HIV positive people, their family members, their friends, their significant others, health educators and service providers, etc.

Training and prerequisites:

- Whenever possible, panelists should be members of the target population of the audience.
- Panels could include any of the following types of speakers: HIV positive people; HIV/AIDS service providers; or friends, family, and significant others of HIV positive persons (all people affected by the epidemic, from a range of social positionings and perspectives).
- Speakers should be trained in basic HIV/AIDS/STD knowledge.
- Participants can provide referrals to agencies, hotlines, and community information resources.

Standards of practice:

- Can be interactive, either single or multiple sessions.
- The site should be comfortable and safe to all participants.

Expected Outcomes:

1) *Increased sensitivity to and destigmatization of HIV/AIDS*
2) *HIV/AIDS knowledge development (about prevention, AIDS 101, antibody testing, treatment, etc.) and debunking of misinformation*
3) *Boosted emotional support and self-esteem of the participants*
4) *Attachment of human faces and stories to audience conceptions of the epidemic*

[24] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

5) *Increased motivation to participate in HIV prevention activities*

MEDIA

Media is a form of communication that can reach large numbers of people with motivational and educational messages. These messages can be designed to reach mass audiences, small and location-specific audiences, or culturally and communally specific audiences.

◊**Large media** can include television (e.g. documentaries, talk shows, commercials, PSAs, etc.), radio (e.g. PSAs, public talk shows, etc.), and print (e.g. newspapers, magazines, etc.).

◊**Small media** can include materials development (e.g. brochures, pamphlets, fact sheets, posters, palm cards, videos, audio tapes, etc.).

◊**Other media** can include billboard advertising, computer services (e.g. Internet, bulletin boards, etc.), and telephone services (e.g. hotlines, talk lines, etc.).

- Should build a solid working relationship with media persons (e.g. writers, reporters, press, etc.), so that HIV/AIDS/STD prevention messages are covered by media in a positive context.
- Media should be developed as relevant to the target populations, through a needs assessment and design process including community participation.

Expected Outcomes:

1) *Increased sensitivity to and destigmatization of HIV/AIDS*
2) *HIV/AIDS knowledge development (about prevention, AIDS 101, antibody testing, treatment, etc.) and debunking of misinformation*
3) *Informing of people, communities, and organizations about local resources and referrals*
4) *Increased motivation to participate in HIV prevention activities*

Effectiveness (of media relations)[25]

A. Outcome Effectiveness

Media relations as a stand-alone strategy for HIV prevention is unlikely to be successful. The placement of prominent media stories that are accurate and informative does play an important role in raising public consciousness, however, and in increasing knowledge of HIV/AIDS within a given community. Media relations can also be useful for dispelling myths and misconceptions concerning the disease.

Media relations activities seek to gain expanded or in-depth media coverage on issues such as myths, volunteerism, discrimination, or education programs and strategies that contribute

[25] From Chapter 4, "Outcome Effectiveness and Cost Effectiveness," California State HIV Prevention Plan, excerpted by Harder + Co.

to HIV prevention. No information could be located that addressed the issue of media relations in regard to HIV/AIDS, although many HIV/AIDS organizations consider the function of media relations to be indispensable to publicizing their programs and services to the general community; in obtaining support for activities; and in notifying potential service populations of the availability of services. As with social marketing programs, an effectiveness evaluation would need to ask how effective media relations strategies are in accomplishing the general goals of public information programs.

B. Cost Effectiveness

Establishing and maintaining positive media relations can be accomplished with very few resources; however, it is unlikely that many actual new infections will be averted with this strategy. It is therefore difficult to measure the costs of media relations activities against the cost saved through AIDS cases averted.

Background -- Use of Media[26]

Media, both general and that directed at specific subgroups in the communities, is influential in teaching about the health risks associated with specific behaviors (20).

- According to published research and other data, media campaigns with culturally-appropriate messages effectively convey prevention information and change behavior when funding exists to sustain them over time (10).

  Media campaigns often require a substantial amount of funds, and therefore many grassroots movement-type organizations cannot afford to sponsor them. Also, several complaints about current media campaigns emerged from focus group data.

- Some focus group participants report being overwhelmed or confused by the variety and inconsistency of media messages.

  For example, messages concerning the safety of oral sex sometimes are confusing or inconsistent.

- Many focus group participants complain that media efforts do not depict peers of target group members.

  For example, African American gay male focus group participants complain that posters only show white people or don't show male couples.

- Media providers note that media messages must be strong to compete for the public's attention.

  Desensitization of the public from exposure to many strong messages, however, is a countervailing concern.

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[26] From Chapter 3, "Strategies and Interventions," presenting the results of the San Francisco Focus Groups for the HIV Prevention Planning Council (1994)

- Providers note that messages are most effective when they are emotionally or intellectually engaging.

  To engage a particular population, providers say media messages should be integrated with other issues and activities of the targeted group. The target population also should be involved in planning and implementing a media campaign.

VENUE-BASED GROUP OUTREACH (This category includes public events interventions.) Community-level venue-based outreach involves a group of individuals who present HIV prevention activities in community settings (e.g. street corners or public forums), commercial settings (e.g. bars, sex clubs, concert halls, and theaters), or public events (e.g. street fairs and parades). The outreach activities may occur in existing settings or settings specially created for the purpose of HIV prevention. Venue-based group outreach can take a variety of forms -- including community theatre, dramatizations of real-life scenarios, "bar zaps," and interactive performance art -- designed to promote HIV risk reductive behaviors among audience members. The distribution of appropriate prevention materials may also be a component of these activities.

Training and prerequisites:

- Outreach activities should be designed and performed by individuals who are members of the target audience.
- Events planning groups should represent the diversity of the community(ies) targeted for education and prevention.

Standards of practice:

- Presentations should be made interactive and fun (as with a "Welcome to San Francisco" theme party for HIV education and prevention targeting tourists).
- Outreach activities should not be disruptive of venue activities, but should respect the operating conditions, and contribute to the spirit, of the venue/event.
- Events should emphasize community unity, creating a positive environment in which participants can socialize and mingle.
- Events should encourage networking amongst members of different communities, through sharing of information and resources.

Expected Outcomes:

1) *HIV knowledge development and debunking of misinformation*
2) *Contribution to the development of a social norm favoring risk reductive behaviors*
3) *Audience member engagement and/or satisfaction*
4) *Personalization of HIV issues and the epidemic -- an increased perception of HIV as personally relevant*
5) *Increased motivation to participate in HIV prevention activities*

SF
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11/9/95

HIV PREVENTION PLANNING COUNCIL
MINUTES
November 9, 1995

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Members Present:
Barbara Adler
Jonathan Brown
Rafael Chang
Thomas Lee Eades
Ellen Goldstein
Fernando Gomez-Benitez
Natalie Gutierrez
Karen Hart
Valerie Kegebein
Yvonne Littleton
Jacqueline McCright
Lidia Mena-Hermida
Ana Claire Meyer
Kerrington Osborne
Les Pappas
Jay Seward
Joshua Volle
Kiki Whitlock
Hank Wilson

Members Absent:
Rafael Diaz
Cynthia Gomez
Robert Hays
Burton Maxwell
Dominic Perez
Juan Rodriguez
Susana Torricella
Phillip Tse
Bobby Wiseman

Guests:
Roe Johnson, AAP
Yolanda V. Lewis, CARP
Chandra Pugh, IRIS Center
Maria Rinaldi, IFR

Harder + Co./Polaris, Inc.:
Mary Irvine
Lyn Paleo

AIDS Office:
Tracey Packer

The meeting convened at 4:20pm.

1. WELCOME & INTRODUCTIONS
Completed.

2. MINUTES OF 10/26/95
Completed. With a quorum present, the minutes of 10/26/95 were approved without exception.

3. ANNOUNCEMENTS
Completed.
Valerie:

- The Co-chairs are beginning negotiations with the people who run the meeting rooms at the First Unitarian Universalist Church, as to whether the HPPC will keep this meeting site.
- The AIDS Office has awarded the TA contract for organizational development and capacity-building to a collaborative team of the Support Center, Harder + Co., Polaris, and Communication Sciences. Next they will consider which agencies should receive which types of technical assistance. Input from the HPPC will be solicited.
- Today (November 9), the AIDS Office is sending out membership nomination forms and letters requesting current members to offer new nominations for the HPPC in the coming year. After this was announced, Kerrington strongly urged members to give their suggestions for nominees.

- An organization in San Francisco is marketing a nightstand self-service condom box; Valerie passed around a picture of the box provided by the distributor, and mentioned that other agencies in S.F. may begin using this promotional item. (See the attached ad.)
- Starting with this meeting, the Co-chairs are splitting up around the room, rather than sitting together on one side of the table. This change has been made in response to requests from new Council members during the last orientation.

Ana Claire Meyer:

- There will be a Strategies and Interventions Subcommittee meeting 9-11am, November 13.

Ellen Goldstein:

- There is a new 60% time position available at CAPS, for a project focusing on collaboration between CBOs and researchers. (See the attached job description.)

Jonathan Brown:

- Brothers' Network will be celebrating World AIDS Day on December 1 from 7-10pm, with an event called "AIDS in Blackface." This evening will include poetry and prose readings, music, and performances by members of the gay, lesbian, bisexual, and transgender communities. (See the enclosed, updated membership list for the address.)

4. STRATEGIES & INTERVENTIONS PRESENTATION

Completed.

Ana Claire passed around an outline (enclosed) for her presentation on the Subcommittee work. She explained that the process represents an attempt to produce guidelines that will be useful to providers in their program design, as well as being useful to the AIDS Office and the Council for local planning. Ana Claire ran through the topics on which general recommendations have been made in the introduction of the Subcommittee document. Next she described what she called the bulk of the Subcommittee work: detailing and standardizing the elements expected of specific strategies and interventions, which have been implemented and have been effective around San Francisco. She reminded Council members that the Subcommittee considered strategies separately in the document, because they can be applied across interventions. Harder + Co. is still working on the effectiveness and behavioral theory portion of the chapter, and the Subcommittee has not yet completed its applicability recommendations for different strategies and interventions.

The applicability recommendations emerged from the Subcommittee's struggle with prioritization of strategies and interventions by population type. After trying to assign rankings to interventions according to various factors influencing effectiveness in the target population, members settled on a prioritization process that would allow a greater role for the provider in making an argument for his/her choice of interventions for the target population. This decision resulted in a set of statements about how certain population characteristics make it easier or more difficult to reach a targeted group with particular strategies and interventions. The applicability recommendations were created as a less mandatory, more flexible approach to prioritization, which will guide providers in deciding upon strategies/interventions, rather than making that decision for them.

GROUP DISCUSSION*

Hank: Has the Evaluation Task Force been informed of these Subcommittee decisions?

* Questions and comments offered here as a record of the discussion are paraphrased rather than verbatim.

Valerie: The Evaluation Task Force is being reconstituted, and people may still join. (Note: A draft of the Subcommittee chapter has been shared with all current members, and they have all had an opportunity to read the applicability recommendations as well, in their capacity as Council members, Subcommittee members, and/or AIDS Office staff.)

Kerrington asked Ana Claire to explain to members why the Subcommittee material is on the agenda. Ana Claire responded that the decision to make general recommendations based on population characteristics, rather than strictly ranking interventions for behavioral groups and/or co-factors, marks a more recent development in the Subcommittee process, which has not yet been approved by the Council. This meeting provides an opportunity to vote on this development.

Valerie: The AIDS Office has asked the CDC to find out how the 64 other sites engaging in this process are managing prioritization. Apparently, none of these other groups have come up with a way to rank strategies and interventions, either. While the set of criteria we use for prioritization may be unique to us, this uniqueness is reflective of San Francisco and is part of the point of the process.

Lyn: It is true that most of the planning groups are struggling with the issue of strict prioritization. They are generally giving some suggestions, but are not using a rigid set of priorities for populations. Through these regional processes, the CDC is getting to see what is practical and realistic with regard to directing the choice of appropriate strategies and interventions.

Kerrington: Could someone on the Subcommittee offer an example of how the applicability information can distinguish between types of interventions to use for different target groups?

Tracey: A lot of the actual prioritization comes in at the program design level. The chapter preamble will stress the steps of (a) identifying what is the issue for the target population, and (b) determining what are the objectives for creating a change in that target population. For a group of people who generally know that they are at risk for HIV, but do not have the skills needed to change their behavior patterns, a multiple session group would likely make an appropriate choice of interventions. For a group of people for whom the issue is that they don't know their HIV status, counseling and testing may be the most helpful first intervention.

Ellen: The Subcommittee also identified a number of essential elements of programs (such as needs assessment, training, and referral capacity), so that higher-quality programs which adequately develop these components can be prioritized over those that do not.

Valerie: It sounds as though the end phase of prioritization will occur at the proposal review stage. In this sense, the Subcommittee is creating the criteria for evaluation of proposals.

Tracey: The criteria should influence proposal development first. Then they will be applied again by the community review panel.

Thomas: The Subcommittee is also concerned that communities be informed ASAP about what we are doing with this process. Community providers will need to be assisted in understanding and implementing these recommendations.

Kerrington: How is the Council decision to prioritize *behavior* reflected in the Strategies and Interventions process?

Ana Claire (?): In creating the applicability recommendations, the Subcommittee considered how interventions work for certain stages of change in knowledge, attitudes, beliefs, and behavior.

Kerrington: Is there something to say that interventions which focus on changing higher-risk behaviors will be placed at higher priority than, for example, general informational campaigns?

Ellen: Even the general information would reach some people who are not identified with their risk or who are not willing to participate in a group intervention. The Subcommittee found it difficult to speak broadly about the worth of a given intervention; it concentrated instead on what could have a positive impact on target groups dealing with different circumstances and situations.

Ana Claire: A general information campaign can also produce some kinds of behavioral change.

Barbara: Counseling and testing can affect client behavior at various points in the program.

Kerrington: My concern is that there has not been a requirement in the past for providers to state, "The focus of our intervention is to change *this* high-risk behavior." We need to be able to expect that level of detail from providers submitting proposals.

Thomas: When the two Subcommittees' work is combined and read in the context of the overall Plan, it will clearly communicate that priority of changing high-risk behaviors within target groups.

Ana Claire: Also, the tasks we're undertaking in December will address the behaviors to be targeted (e.g., in the program design piece of the Plan).

Valerie: It will be important to state explicitly that we are targeting specific behaviors, so that providers will know what to expect and will not be misled as they write their proposals.

Thomas: We will also need to put the total document together in such a way as to produce a flow and ease of reading, with a preamble explaining just what we are trying to accomplish. We may need to add a manual or guide to the Plan, to make it user-friendly.

Hank: I think of the word "priorities" as suggesting some hierarchy. What may be effective in one target group may have no relevance for another target group. Where does that kind of variability fit into what we're calling priorities?

Ana Claire: The Subcommittee's decision was based on a drive to create a document that will be useful to providers in deciding what will work for their populations. This is why the applicability information does not specify a 1-2-3-4-5 ranking of strategies or interventions, but describes instead how one intervention may be more helpful than another when combined with a certain population characteristic.

Thomas: We also wanted to allow for the possibility that a provider may come up with an effective intervention that we wouldn't have expected to work with their target population.

Kerrington: So, are we really talking about the *criteria* which delineate the priority elements for strategies and interventions?

Ana Claire: The Subcommittee has begun to make statements about what works better for whom.

Valerie: (1) It should be stated somewhere that multiple-session groups have been found to be important for behavioral change.
(2) I would like to applaud the Subcommittee and the technical support team for the extensive work that has gone into this document.

Ellen: The Subcommittee applicability recommendations should be recognized as a process piece, which walks people through a difficult process of prioritization.

Rafael: Will we be voting on the format or content of the chapter, or both?

Ana Claire: It is still incomplete (not all the content is there yet). For example, the issue around how to break down street and venue-based outreach has not yet been resolved in the Subcommittee.

Lyn: Since the basic document was already approved, it is the newer prioritization process that is up for a Council vote. Members are voting with the understanding that the chapter will continue to be wordsmithed, expanded, defined, and revised.

The Motion: That the Council approve the concept for prioritization and the general direction that the Strategies and Interventions document is taking.

Rafael: Have there been outcome effectiveness studies performed on social marketing?

Ana Claire: We're still gathering this information. Lyn is doing a search to re-write some of the effectiveness information now, along with some data Ellen has provided.

Kerrington: The only data I've seen on American social marketing efforts looks at cigarette campaigns as social marketing. There do not seem to have been American studies of social marketing around HIV prevention.

The Vote:	In favor	13
	Opposed	0
	Abstentions	4

The Subcommittee process for recommending applicability of interventions, and the general direction of the Strategies and Interventions chapter both stand approved.

5. BREAK

6. PRIORITY SETTING PRESENTATION
Completed.
Joshua opened by introducing himself and Rafael Chang as the Subcommittee Co-chairs. He clarified that the Council would be voting on the following items:
1) The Subcommittee's method of including transgender communities in the behavioral matrix
2) The list of co-factors influencing the risk of HIV transmission
Joshua summarized the Subcommittee process as one that begins with highly quantifiable variables, and then moves into qualitatively focused priority setting.

The priority setting matrix shows, for each behavioral population, the frequency of a risk behavior multiplied by its relative risk. In order to include the transgender population clearly in the priority setting process, the behavioral groups in the matrix were expanded. The 12 basic categories were reframed in the following manner:

1.)MSM-IDU → MSM-IDU; MTF (pre-op)SM-IDU; FTM (post-op)SM-IDU
2.)MSM&W-IDU → MSM&W-IDU; MTF (pre-op)SM&W-IDU; FTM (post-op)SM&W-IDU
(and so on...)

Text was also created to spell out the actors, actions, and objects (who does what with whom or with what) pertaining to each of the abbreviated behavioral categories.

The process for prioritization by this Subcommittee remains the same -- coming up with a score for frequency multiplied by relative risk, then adjusting it for prevalence in the population and again for population size, in order to achieve a basic ranking for each behavioral group (Phases I and II). Then, in Phase III, co-factors are taken into consideration (Joshua read through the seven co-factor categories and their key examples). Phase IV allows individuals applying for funding to change the basic score using available data, and/or to discuss the co-factor issues related to their target population. Using the Strategies and Interventions program planning and population-specific guidance, providers will also be able to describe how the co-factors pertinent to their target group have influenced their choice of strategies and/or interventions, and how the chosen strategies and/or interventions will meet the needs suggested by the presence of those co-factors in the target group.

GROUP DISCUSSION*

Kerrington: Are we going to be changing the category components from "men" and "women" to "males" and "females," in order to address youth at risk, as Karen suggested?

Joshua: Yes; that change was approved by a vote in Council, but has not yet been incorporated into the document.

Rafael: The Priority Setting Subcommittee has not yet assigned any separate rankings for the transgender groups within behavioral categories.

Kerrington: I thought that the risk only changed in the case of an MTF(post-op) transgendered person having receptive vaginal intercourse.

Joshua: Yes; the behavioral groups, including their transgender components, will stay where they are now in the ranking system (1-12). However, the issue Kerrington has mentioned will be explained clearly in the narrative of this section.

Ana Claire: Wouldn't this issue of different risk come up during the RFP process (Phase IV)?

Joshua: It would, but first we have to offer providers that particular relative risk value.

Karen: I would like to see age listed as its own co-factor (rather than just as age-based discrimination, or ageism, in the *discrimination* category). Listing it separately gives a different emphasis to the need to address youth with prevention and education.

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* Questions and comments offered here as a record of the discussion are paraphrased rather than verbatim.

Joshua: The issues faced by youth could all be described through the examples under the broader co-factor categories we have now (such as perception/lack of perception of susceptibility, under *social/cultural* co-factors).

Karen: Wouldn't it make a difference, though, in the assigning of weights to co-factors?

Joshua & Rafael: We decided not to assign any weights to the co-factors, for the same reasons that the Strategies and Interventions Subcommittee decided not to assign strict priority ratings to the various strategies and interventions by target population. It is not feasible to rank co-factors. We can't say for a given population whether, for example, poverty, lack of access to services, or discrimination has a greater impact on susceptibility than the other relevant co-factors.

Lyn: The Subcommittee talked about the issue of not including specific demographic characteristics like ethnicity, gender, and age. We have a lot of data on youth (e.g., youth and self-esteem, and youth and sexual abuse), which has been incorporated in detail in the chapter. There are many mentions of youth throughout the Priority Setting document.

Karen: The problem is that this approach is not inviting to providers intending to serve youth. They can't see immediately how youth fit into the process for setting priorities, since youth does not appear as an independent co-factor.

Lyn: The chapter discussion should make any provider who reads it understand how to explain youth issues as affecting the target population.

Karen: I would still like to make the suggestion that youth be included as a separate co-factor.

Kerrington: Then we should defer this recommendation until the voting.

Ana Claire: Where do runaway youth or kids in shelters fit into the Priority Setting process?

Joshua: They could be described by the co-factors of homelessness and financial instability, among others.

Ana Claire: Can we add biphobia under discrimination? (2nd recommendation put up for the vote)

Ellen: Can someone explain the two numbers in the boxes for the matrix?

Joshua: The first number represents the estimated frequency of acts, and the second number represents the product when that frequency is multiplied by relative risk.

Lyn: Thanks for pointing out that ambiguity; it will be clarified in the final document.

Ellen: What are the numbers near the edge of the matrix, next to the grand totals?

Lyn: Those "population scores" were derived from a scale for population size.

Les: Can we change the behavioral co-factor of substance abuse to substance use/abuse, and add this co-factor to the *discrimination* category, also? (3rd recommendation put up for the vote)

Valerie: For ease of reading, I would recommend moving the modifiers for each behavioral group to the end of the string, so that it goes: 1.) M, MTF (pre-op), FTM (post-op.) *SM-IDU* (4th recommendation put up for the vote)

Kiki: Regarding the higher risk of MTF transgendered persons having receptive vaginal intercourse, I have heard that this issue applies particularly to people with recent gender conformation surgery. The healing process may take up to about a year, and it is during that first year that the likelihood of tissue tears could lead to a significantly higher risk.

Jay: Are the suggestions being made considered "friendly amendments" in this process?

Response from Lyn, Valerie, and others: No. The ones that require changes beyond a basic clarification will receive a separate vote from the main vote (on the process for inclusion of the transgender community).

Karen: On page 2 of the Interim Report to the CDC, under **Principle**, there are two ambiguous statements:

- "If a woman has sex with any man in San Francisco her odds of having sex with a man who is HIV-infected are 1 in 140."
- "If a man has sex with any man in San Francisco his odds of having sex with a man who is HIV-infected are 1 in 80."

This language does not clearly indicate whether, in the second statement, we are making a qualification about men who normally have sex with men. What exactly do we mean here?

Kerrington: The "any man" in the second case actually relates to men who have sex with men *and* men who have sex with men and women -- in other words, those men who are available to have sex with a man. It's true that the language is unclear, and needs to be revised.

Valerie: This quote is an excerpt from last year's Plan, so we should not focus too much attention on it here.

Hank: I would like to make a motion to hear public comments before the vote, since they might generate more questions for discussion.

Kerrington (after noting responses from around the room): There seems to be general agreement reached in favor of hearing public comments regarding this material before the vote.

7. PUBLIC COMMENTS

Completed.

Yolanda Lewis: Thank you for taking comments now; I was supposed to have left this meeting about ten minutes ago. How is the Council defining pre-op and post-op?

Joshua: Post-op refers to completed surgery, whereas pre-op indicates that surgery has not been completed.

Kiki: Actually, the definition depends on whether we are talking about FTM or MTF.

Yolanda: There can be several different changes. For example, where would an FTM who has had top but not bottom surgery fit in the Priority Setting behavioral categories?

Lyn: The categories make a distinction about whether or not a person has undergone phallioplasty or genitalplasty -- but do not distinguish between people who have or have not undergone a mastectomy or breast implant surgery. The risks are not likely to alter as a result of top surgery.

Roe Johnson: (1) Regarding the "any man" statements, the planning group for last year was also considering the chances that the pair (a woman and any man or a man and any man) would engage in unprotected anal intercourse, increasing the risk of HIV transmission. (2) I work in massage parlors doing outreach, prevention case management, and prevention education. In this work, we actually take women to different clinics for services and act as their advocates (often they don't speak English). I would like the document to show that providers should have sensitivity trainings/in-services (e.g., regarding the issues of sex workers and of gay, lesbian, bisexual, and transgender people). Prevention education is as important as preventive medicine, in my opinion. But a lack of sensitivity among providers can bar people at risk from seeking prevention services.

Kerrington: We seem to have moved into a more general discussion. I have heard just one suggestion on how to change the method for inclusion of the transgender population.

Kiki: Actually, that suggestion (about moving the descriptions of the behavior(s) to the end of the string for each category) was already discussed in the Subcommittee. It does not require any change to the method of inclusion; it would simply entail a quick re-writing of the categories for the sake of succinct presentation.

The Vote (on how the Priority Setting process has changed to account for transgendered persons): The Council unanimously voted in favor of the method chosen for including transgendered persons.

Suggestions for Clarification:
1.) The document will include explanations for each type of number found in the matrix.
2.) The statements about the likelihood that "any man" might be HIV-infected will be clarified.
3.) There will be a note about the particular type of surgery determining "pre-op" or "post-op" status for the purpose of assigning risk scores to target populations

Amendments Accepted to the Subcommittee Document:
1.) Biphobia has been added as a key example under the *discrimination* co-factors.
2.) The phrase "substance use/abuse" will replace "substance abuse" throughout the document, and will be added as a behavior which can result in the co-factor of *discrimination.*

After a brief discussion over the possible differences for providers who target substance users as opposed to substance abusers (or vice-versa), the Council reached general agreement that a distinction should not have to be made in the document between substance users and substance abusers; and that it would be too difficult to make such a separation, considering the radically subjective and variable interpretations of these terms, especially as they relate to personal identity. Kiki pointed out that many providers target both substance users and substance abusers. The Council also decided to consider drugs as illicit drugs for the time being, excluding prescription drugs. Joshua added that the provider applying for funds will have to give a narrative explanation of how the substance affects HIV risk in the target population, rather than just going through a check-off list of co-factors.

The discussion on age as a potential co-factor resulted in a decision to maintain consistency with the earlier Council decision *not* to include race and ethnicity as independent co-factors, since the risks associated with these demographic characteristics can be expressed in more detail using different co-factor categories (such as *poverty, discrimination, lack of access*, etc.). These other categories can more accurately be viewed as directly aggravating HIV risk than can the categories of race, ethnicity, or age. Ana Claire said that the most cogent factors related to youth, as she understands them, are discrimination and homelessness. It is not who you are, she added, but what you do that puts you at risk for HIV transmission. This has been the theme governing the planning effort (which made a commitment to emphasize behavioral risk). Jay asked that the text on youth be highlighted in such a way that the relation between age and risk does not fall out of the larger picture presented in the Priority Setting chapter. Lyn assured the Council that this information is included in the chapter, and will become clear to those who read it.

The Vote (as to whether to include youth as a separate co-factor category):

In favor	3
Opposed	11
Abstentions	3

This motion failed.

The Vote (as to whether to accept the co-factors list with the additions mentioned above to the *discrimination* key examples):

In favor	16
Opposed	1
Abstentions	0

The co-factors list stands approved.

The Council adjourned at 6:15pm.

8. EVALUATION (13 of the 19 Council members present turned in marked evaluation forms.)
1.) The achievement of the objective "To meet other HPPC members, learn more about and better appreciate their areas of expertise and contributions to planning" was rated at an average of **5.27** (with 11 of the 13 respondents answering).
2.) The achievement of the objective "To hear about, understand and adopt the report on Strategies and Interventions" was rated at an average of **7.62** (with all 13 respondents answering).
3.) The achievement of the objective "To hear about, understand and adopt the report on Priority Setting" was rated at an average of **9.0** (with 12 of the 13 respondents answering).
4.) The achievement of the objective "To hear and understand public comments" was rated at an average of **8.58** (with 12 of the 13 respondents answering).
There were no written comments on any of the evaluation forms.

Next Council Meeting: Thursday, December 14, from 4-6pm -- at the First Unitarian Church
Next Priority Setting Meeting: Thursday, November 16, from 4-6pm -- at the AIDS Office
Added Strategies and Interventions Meeting: Monday, November 20, from 1-3pm -- AIDS Office

Minutes recorded by: Mary Irvine
Minutes approved by: Valerie Kegebein

San Francisco
HIV Prevention Planning Council

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MEMORANDUM

DATE: November 3, 1995

TO: Council members

FROM: HPPC Co-chairs

SUBJECT: Interim Report to the CDC on HPPC Committees' Planning Efforts

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On behalf of the HPPC, we have prepared this Interim Report for submission to the CDC. This report outlines the prevention planning efforts of the HPPC Committees during the second year of the planning process. It also includes the most recent draft of the Strategies and Interventions chapter. Please review the entire report carefully and make any comments, corrections and clarifications.

There will be a discussion of this report at the full Council meeting on November 9. This will be the final opportunity for Council members to give their feedback on the document. While most aspects of the report have been approved previously, final decisions on the acceptability of the contents of the document will be made at this meeting.

As explained in the report, the Strategies and Interventions chapter is still missing several components, including a section on behavior theory, and expanded effectiveness information.

INTERIM REPORT ON HPPC COMMITTEES' PREVENTION PLANNING EFFORTS

PURPOSE OF THIS DOCUMENT

This document describes the activities of San Francisco's HIV Prevention Planning Council (HPPC) in the second year of the planning process. Year one of the planning process laid a solid foundation, and year two efforts have built upon that foundation. The foci of efforts to date have been prioritizing HIV prevention needs and interventions. Two committees have met weekly and the full Council has meet monthly to conduct these activities. The Priority-setting Committee has developed a four-phase model for prioritizing needs, and the Strategies and Interventions Committee has developed specific, detailed guidance for health education to priority populations.

This report describes the process for decision making and the decisions of the committees. It will be distributed to the CDC as additional support for the AIDS Office application and to Council members in preparation for the adoption of committee decisions. While the committees have made progress reports to the Council, and Council members have adopted elements of the overall decision, this document and the committee presentations to the Council will represent for the first time the entirety of the decisions.

The results of the committees' work, once adopted by the HPPC, will be written and distributed as two chapters that supplement the year one San Francisco HIV Prevention Plan. During the first part of 1996, these committees will be disbanded and Council members will form new committees to review and update other chapters of the year one plan. The complete updated plan will be issued in early summer of 1996. The two chapters that will be produced as supplements to the year one plan will contain:

Priority-setting Chapter

- brief description of decision-making process;
- explanation of the four phases;
- prioritized list of behavior groups and Phase I and II matrix;
- description of factors that increase susceptibility to HIV (co-factors);
- summary information about frequency of behaviors;
- summary information about relative risk;
- background information on transgender physiological risk;
- guidance to providers of how to apply the Phase I formula to target groups.

Strategies and Interventions Chapter

- brief description of decision-making process;
- overarching themes in program design;
- description of each strategy and intervention;
- standards of practice for each intervention;

- effectiveness of each intervention;
- applicability of each intervention.

PRIORITY-SETTING COMMITTEE

Criteria for decision making

In year one of prevention planning, the Council formed several principles for priority-setting. In year two of HIV prevention planning, the HPPC's Priority-setting Committee carried forward these principles as they developed a four-phase process for priority setting. These principles, described in the year one Plan, are presented below:

Principle:[1]

There is only one factor for determining which populations need focused prevention efforts: namely, a significant risk of contracting HIV. Risk of contracting HIV is caused by practicing certain identifiable behaviors.

This plan is concerned with the prevalence of HIV in San Francisco.

According to the CDC, as of December 1993, San Francisco has the highest rate (287.5 per 100,000) of AIDS cases of any metropolitan area in the United States. Therefore, all people in San Francisco who practice behaviors that could lead to the transmission of HIV are at high risk for contracting HIV. For example:

If a woman has sex with any man in San Francisco her odds of having sex with a man who is HIV-infected are 1 in 140. If restricted to men who have sex with women this ratio changes to 1 in 160.

If a man has sex with any man in San Francisco his odds of having sex with a man who is HIV-infected are 1 in 80. If restricted to men who have sex with men this ratio changes to 1 in 4.

However, the prevalence of HIV in any population means nothing in the absence of behavior; therefore, if we consider all San Franciscans to be at high risk due to the presence of the virus in our region, we must make efficiency of HIV transmission our next level of criteria. From the most effective transmission to least effective within each category, the following are the primary factors for selecting priority target groups:

BLOOD to BLOOD:
- Injection Drug use
- Perinatal
- Cunnilingus during menses
- Other blood to blood exposure

SEMEN to BLOOD:
- Anal receptive
- Anal insertive
- Vaginal receptive
- Fellatio

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[1]. San Francisco HIV Prevention Plan, 1995. Chapter 4, pp. 1 - 3.

VAGINAL Secretions to BLOOD:
Vaginal (female to male)
Cunnilingus

VAGINAL Secretion to VAGINAL (hypothetical: no current epidemiological evidence)

Physiological Co-Factors

Beyond the actual behaviors, co-factors will be considered which increase the risk of contracting HIV with a given behavior. These co-factors are to be used along with the primary factors listed above in determining priority of risk groups. Co-factors include poverty, age, substance use, and other factors which increase the efficiency of transmission of HIV.

For example, it has been demonstrated that the health of poor women is compromised by typically inadequate nutrition; in particular, the vaginal walls are weaker and more susceptible to bleeding. Thus, poverty as a co-factor places low-income women at a greater risk than other women for contracting HIV through semen to blood transmission during intercourse.

Substance use has been shown to be linked with various dimensions of decreased health status including thin cell walls, pseudo anemia, and poor nutrition. Age has been linked with decreased resistance to disease in general. Other physiological co-factors may be considered based on scientific evidence.

The presence of more than one behavior or physiological co-factor may well have a "multiplier-effect" in terms of risk of infection. This issue is not addressed specifically in these criteria beyond the data that currently exists.

Behavioral Co-Factors

The criteria for identifying target risk groups are the behaviors which put people at risk of contracting HIV. The following types of information will be used to inform the identification of groups practicing high risk behaviors, and to better understand the existence and causes for high risk behavior.

Epidemiological data, including incidence and prevalence of HIV, and various surrogate markers provide evidence that high risk behavior is taking place. As the quality and consistency of these measures increases, changes in these measures over time will be one source of data to track changes in behaviors.

Evidence of high risk behavior and attitudes which are linked with high-risk behavior are clearly essential to the identification of relevant priority sub-groups for prevention efforts. Knowledge, Attitudes, Beliefs and Behavior Studies (KABBs), documented program service data and the experience of providers are all sources of information about the extent and nature of high-risk behavior in population sub-groups.

In addition, issues such as low knowledge or situational factors related to high-risk behavior (such as incarceration) are to be considered when establishing and defining the target groups for prevention efforts.

In year one of the planning process, the Epidemiologic Committee established 12 transmission, or behavior, groups.[2] To assemble a comprehensive picture of the epidemic in San Francisco, city-wide social and demographic data, AIDS case data (observed and projected), estimated seroprevalence data, published seroprevalence and seroincidence studies, counseling and testing data, surrogate marker data (STDs, Teen Pregnancy, TB and Substance Abuse), published behavioral studies and program and community level KABBs

[2]. San Francisco HIV Prevention Plan, 1995. Chapter 1 p. 2.

were gathered and analyzed according to the twelve transmission risk groups that were developed by the Epidemiologic Committee and approved by the full HPPC Council. These transmission groups emphasize the need to organize epidemiologic data and characterize the risk of infection based on behavior rather than the traditional "risk" groups that have been used in the past. The HPPC Transmission Groups are listed below, not in rank order:

Behavior Groups	Abbreviation
Women who have Sex with Women	WSW
Women who have Sex with Women and Inject Drugs	WSW-IDU
Women who have Sex with Men and Women	WSM&W
Women who have Sex with Men and Women and Inject Drugs	WSM&W-IDU
Women who have Sex with Men	WSM
Women who have Sex with Men and Inject Drugs	WSM-IDU
Men who have Sex with Women	MSW
Men who have Sex with Women and Inject Drugs	MSW-IDU
Men who have Sex with Men and Women	MSM&W
Men who have Sex with Men and Women and Inject Drugs	MSM&W-IDU
Men who have Sex with Men	MSM
Men who have Sex with Men and Inject Drugs	MSM-IDU

Members of the Priority-setting Committee based their decision-making upon this guidance from year one process. Essentially, members were interested in a priority-setting model that had a basis in science and made good use of existing data. The crucial elements of the model needed to be frequency of risk behaviors, prevalence of HIV, and presence of co-factors that could increase risk for HIV.

Process for Decision-making

The Committee met approximately weekly for five months to develop the model for priority setting. There were approximately ten regularly participating members, and several members who attended meetings less frequently. The two co-chairs of the Committee facilitated the meetings and structured the agendas. AIDS Office staff and community co-chairs participated on the Committee. Technical support was provided by the consultants. The model was developed through discussion among Committee members. Often, group discussion resulted in consensus to proceed in a specific direction. When consensus was not obvious, issues were decided by majority vote. In most cases, when a vote was taken, the result strongly indicated a specific direction; that is, all but one or two were in agreement. Members were sensitive to each other's opinions, and when an issue arose that one or two members disagreed with the majority, attention was paid to the minority opinion.

The Committee had to resolve tensions based on different conceptual approaches to prioritization. On the one hand, many saw utility in a numerically-based formula. On the other hand, many wanted to include in the process the complexities inherent in prevention that could not be supported in a formula-based approach. This tension was mediated by adopting a model that incorporated both approaches. Part of the model (Phases I and II) categorizes and ranks behavior groups through the use of a formula (described later in this report). Another part of the model

(Phase III) takes into account the complexities of the epidemic through the inclusion of a host of factors that increase susceptibility to HIV or present challenges to prevention efforts.

A second area of tension was between behavior and identity, between the general ranking of behavior groups and the specific assessment of target groups' risk. The model for priority setting bridges this tension by incorporating mechanisms for the general ranking of behavior groups (Phases I and II) and the specific ranking of identity-based target groups (Phase IV). The ranking of behavior groups (Phases I and II) was based on behavior, rather than identity (e.g. self-identified lesbians who have sex with men are ranked on the basis of behavior with both women and men). However, providers are encouraged (in Phase IV) to identify sub-populations most at risk within these behavior groups and to use the formula and co-factors to describe the specific risk of the identified group.

Community input was obtained in a variety of ways. Public comment occurred at the council meetings, and this public comment was referred to in the Committee discussions. Providers on the council brought with them their experience and their connections to other providers and consumers; these experiences naturally were drawn into the discussions. At one point, members of the transgender community provided extensive comment to the Committee for two weeks to enable the Committee to fit into its model the transgender groups. Initially, these discussions were difficult because the Committee had not established a mechanism to receive public comment outside of the full council meetings, and the representatives of the transgender community were vehement in their opinions. However, the discussions continued and satisfactory resolution was reached. This experience enabled the Committee to clarify the methods for public comment to the Committee.

The Decisions

The Priority-setting Committee established a four phase process for prioritizing groups at risk. A summary of the four phases is presented below, followed by detailed information about each of phases. In reading this information it is important to bear in mind the Committee's definition of behavior group and target group: behavior groups are defined based on behavior, rather than identity. Examples of behavior groups are men who have sex with men, women who have sex with men, men who have sex with women and inject drugs. Target groups are defined by identity, not necessarily sexual behavior. Target groups are defined by the prevention provider who intends to serve a group; therefore, the group may be narrowly defined (such as African-American commercial sex workers) or broadly defined (such as injection drug users).

- **Phase I** prioritizes behavior groups using a matrix that has the estimated average annual frequency of risk activities and an estimated relative risk value for each activity.

- **Phase II** adjusts the Phase I score by including prevalence and population size for each behavior group. Phases I and II form the basic ranking of behavior groups.

- **Phase III** identifies seven categories of co-factors and provides key examples for each. The year two Prevention Plan will contain a description of these co-factors and their role in HIV transmission.

- **Phase IV** allows providers submitting applications for funding to apply the Phase I formula to their specific target group, and requires providers to describe the presence of co-factors in their target group (this information would be included in an needs statement).

Each of the phases is described in more detail below.

Phase I - Behaviors and relative risk

Developing and testing the matrix

Using the list of primary factors for HIV transmission (such as injection drug use, anal receptive intercourse, and so forth) and the behavior groups (MSW, WSM, and so forth) identified in the year one process, the Committee established a matrix of the twelve behavior groups and 15 behaviors that corresponded to the possible routes of HIV transmission. Committee members tested the matrix as a model for prioritizing behavior groups, using "best-guess" estimates. Into each cell, members agreed upon and wrote an estimate of the average number of times that behavior group engaged in that act annually. Each cell was multiplied by an estimated relative risk score (indicating the greater or lessor risk of one act when compared to another) for each act, and a total for each row was calculated. There was a range of total scores from just over 2,000 to over 12,000, indicating that the model differentiated between groups (if the scores had been close this would indicate that the model was not sufficiently sensitive to the differences in behaviors among the groups and would have not been useful). Having passed the test, the Committee proceeded with the model, and the consultants were asked to provide information about the average annual frequency of acts for each behavior group and an estimated relative risk score for each act.

Gathering information about frequency of behaviors

The consultants reviewed HIV and sexuality literature, and, using 30 sources, developed a packet of information for the Committee that highlighted what was found about the frequency of the behaviors for each behavior group. The consultants were able to find credible sources of information for the highest risk acts. It was difficult to find information about sharing unclean sex toys and other blood to blood transmission (including tattooing, ear piercing, sharing injection drug paraphernalia other than needles, and acupuncture with unsterile needles). Fortunately, these acts have a low relative risk score, so even great variations in the frequency has little effect in the final Phase I score. A summary packet was provided to Committee members.

Estimating relative risk

The Committee debated whether to use infectivity rate or relative risk. Infectivity rate is often defined as the percent chance of becoming infected per episode. Relative risk indicates how risky one act is compared to another. The consultants queried over a dozen researchers about these issues and prepared a report for the Committee. The report stressed that:

> the Priority-setting committee is developing what the policy arena would consider a complex model and the scientific community would consider a simple model. The model is not comprehensive or complex enough to take into account all the elements of risk for all the sub-communities where risk occurs - it is not sufficient to accurately predict the number of new infections that will occur, and this troubles many researchers, especially epidemiologists who develop models as predictive tools. As one said, "Modeling can be falsely reassuring if the data are shaky." The model, though, is not intended as a epidemiology tool, but rather as a guide to policy-making. To be useful as a policy aid, the model should do (at least) two things:
>
> - Take into account the most important factors about risk and
> - Serve as a guide to policy rather than as a concrete answer.

The committee will have to make the policy recommendations, using the results of the model as a guide.

Estimates of both relative risk and infectivity rates are problematic because no one is certain. A great deal of individual difference seems to exist. Also, the probability varies depending on how infectious the partner is. It appears that people in the very early stage of HIV (from infection to some time after antibodies develop) are highly viremic; those in the stage from a few months after infection to just before they become symptomatic are less viremic; viremia increases again in the symptomatic state (but probably does not reach the levels of viremia of the early stage); viremia then decreases sometime after an AIDS-defining condition. The fluctuating viremia makes it difficult to establish a per episode infectivity rate. The issue of viremia fluctuations can be ignored in the Committee's model since the Committee is dealing with groups of people, not individuals (and because taking it into account is impractical for policy-setting) - within each of the behavior groups, there are people at all stages of viremia.

A second problem in estimating relative risk or infectivity rates is that less information is known about the lower-risk acts. Infectivity or relative risk has been studied for sharing needles, anal receptive sex, and vaginal receptive sex - the acts with the highest risk. It is hard to determine the risk of fellatio, since most people in these studies engaged in both intercourse and fellatio. But there is general agreement that several of the acts are of low risk.

A third issue is that some researchers cite infectivity rates as estimates of the percent chance of becoming infected per partnership, rather than per exposure (act). Estimates of per partnership may be more reliable. There are several good studies of discordant couples. These studies do not look at what acts the couples do, but track when/if the negative partner seroconverts. The benefit of this approach is that the information may be more reliable; the drawback is that we have not found this information for all the behavior groups - most of the discordant couples studies are among heterosexual couples.

After reviewing this information, the Committee selected to use relative risk per act, since information was more easily estimated. The consultants surveyed the literature and spoke to researchers to obtain estimates of relative risk. The Committee discussed the findings and chose relative risk rates as follows:

Act	Relative Risk
Sharing unsterile needles	12
Anal receptive intercourse	9
Vaginal receptive intercourse	3
Vaginal insertive intercourse during menses	2
Anal insertive intercourse	2
Vaginal insertive intercourse	1.5
Giving fellatio	1
Giving cunnilingus during menses	1
Giving cunnilingus	0.5
Other blood to blood transmission	0.5
Getting cunnilingus	0.1
Getting fellatio	0.1
Sharing unclean sex toys	0.1
Vaginal to vaginal contact during menses	0.002
Vaginal to vaginal contact	0.001

The number "3" for vaginal receptive intercourse was chosen arbitrarily as a starting point to which the other behaviors could be compared and assigned a risk rate relative to that number. For example, Committee members felt that sharing unsterile needles was four times riskier than vaginal receptive intercourse, so its relative risk score became a "12."

The Committee reviewed the packets of information about the behaviors the frequency of acts for the behavior groups, and asked the consultants to assist in working with the numbers to estimate an average frequency. The Committee reviewed and discussed the results and adopted them.

Phase II - Prevalence and population size

Using information from the year one San Francisco HIV Prevention Plan on prevalence and population size, the Committee quickly inserted these numbers into the matrix. Rather than using the actual population size, the Committee grouped population size into four categories:

1) 0 - 1,000
2) 1,001 - 10,000
3) 10,001 - 100,000
4) 100,001 and over

The results of Phase I and Phase II provided a ranking of the behavior groups, as follows:

1. Men who have Sex with Men and Inject Drugs MSM-IDU
2. Men who have Sex with Men and Women and Inject Drugs MSM&W-IDU
3. Men who have Sex with Men MSM

4.	Men who have Sex with Men and Women	MSM&W
5.	Women who have Sex with Men and Inject Drugs	WSM-IDU
6.	Men who have Sex with Women and Inject Drugs	MSW-IDU
7.	Women who have Sex with Men and Women and Inject Drugs	WSM&W-IDU
8.	Women who have Sex with Women and Inject Drugs	WSW-IDU
9.	Women who have Sex with Men and Women	WSM&W
10.	Women who have Sex with Men	WSM
11.	Men who have Sex with Women	MSW
12.	Women who have Sex with Women	WSW

At this point, the Committee received extensive comment from representatives from the transgender communities. Several meetings were devoted to issues of how best to include transgender groups in this prioritization process. Several options were considered and rejected including:

- creating 12 additional categories for post-operative transgender groups;
- adding four categories (female-to-male pre-op; female-to-male post-op; male-to-female pre-op; and male-to-female post-op);
- adding four categories (female-to-male post-op; male-to-female post-op; male-to-female post-op IDU, and female-to-male post-op IDU;
- Using parenthesis with the current behavior categories to note the inclusion of transgender groups in their corresponding behavior groups.

The Committee decided, using appropriate terminology and spelling things out clearly, to include pre- and post-operative transgender groups in the current categories as follows:

1. Men who have sex with men and inject drugs; transgender male-to-female (pre-operative) who have sex with men and inject drugs; transgender female-to-male (post-operative) who have sex with men and inject drugs.
2. Men who have sex with men and women and inject drugs; transgender male-to-female (pre-operative) who have sex with men and women and inject drugs; transgender female-to-male (post-operative) who have sex with men and women and inject drugs.
3. Men who have sex with men; transgender male-to-female (pre-operative) who have sex with men; transgender female-to-male (post-operative) who have sex with men.
4. Men who have sex with men and women; transgender male-to-female (pre-operative) who have sex with men and women; transgender female-to-male (post-operative) who have sex with men and women.
5. Women who have sex with men and inject drugs; transgender female-to-male (pre-operative) who have sex with men and inject drugs; transgender male-to-female (post-operative) who have sex with men and inject drugs.
6. Men who have sex with women and inject drugs; transgender male-to-female (pre-operative) who have sex with women and inject drugs; transgender female-to-male (post-operative) who have sex with women and inject drugs.

7. Women who have sex with men and women and inject drugs; transgender female-to-male (pre-operative) who have sex with men and women and inject drugs; transgender male-to-female (post-operative) who have sex with men and women and inject drugs.
8. Women who have sex with women and inject drugs; transgender female-to-male (pre-operative) who have sex with women and inject drugs; transgender male-to-female (post-operative) who have sex with women and inject drugs.
9. Women who have sex with men and women; transgender female-to-male (pre-operative) who have sex with men and women; transgender male-to-female (post-operative) who have sex with men and women.
10. Women who have sex with men; transgender female -to-male(pre-operative) who have sex with men; transgender male-to-female (post-operative) who have sex with men.
11. Men who have sex with women; transgender male-to-female (pre-operative) who have sex with women; transgender female-to-male (post-operative who have sex with women.
12. Women who have sex with women; transgender female-to-male (pre-operative) who have sex with women; transgender male-to-female (post-operative) who have sex with women.

Using the abbreviations, the priority behavior groups are as follows (FTM= transgender female-to-male; MTF=transgender male-to-female; S=sex; M=male or men; W= Women):

1. MSM-IDU; MTF (pre-op)SM-IDU; FTM (post-op)SM-IDU
2. MSM&W-IDU; MTF (pre-op)SM&W-IDU; FTM (post-op)SM&W-IDU
3. MSM; MTF (pre-op)SM; FTM (post-op)SM
4. MSM&W; MTF (pre-op)SM&W; FTM (post-op)SM&W
5. WSM-IDU; FTM (pre-op)SM-IDU; MTF (post-op)SM-IDU
6. MSW-IDU; MTF (pre-op)SW-IDU; FTM (post-op)SW--IDU
7. WSM&W-IDU; FTM (pre-op)SM&W-IDU; MTF (post-op)SM&W-IDU
8. WSW-IDU; FTM (pre-op)SW-IDU; MTF (post-op)SW-IDU
9. WSM&W; FTM (pre-op)SM&W: MTF (post-op)SM&W
10. WSM; FTM (pre-op)SM; MTF (post-op)SM
11. MSW; MTF (pre-op)SW; FTM (post-op)SW
12. WSW; FTM (pre-op)SW; MTF (post-op)SW

Please note that the rank order of the behavior groups did not change; this revision simply adds transgender groups in their equivalent behavior category based not on identity but on potential behavior.

Phase III - Co-factors

Simultaneously to developing the Phase I and Phase II matrix, the Committee developed Phase III. The Committee developed a list of co-factors - factors that increase one's susceptibility to HIV infection, increase the likelihood that one would be exposed, increase risk behavior, or decrease ability to receive and act upon HIV prevention messages. Each factor was defined, and

its role in increasing susceptibility to HIV was discussed. The consultants were asked to collect information from the literature and interviews about these co-factors. The Committee placed items from the list into seven categories.

Initially, the Committee planned to assign a weight to each co-factor and this weight would stand alongside the behavior group score (from Phase I and II) to determine priorities. However, upon reflection, members realized that the issues are too complex to assign a weight that would place one co-factor above another in its contribution to HIV. This decision in no way diminished the importance of the co-factors; rather, it established that all of the co-factors have a role in HIV prevention efforts and are present in various combinations in various populations.

The Committee decided that there would be seven categories of co-factors with key examples in each category. The consultants will write a detailed description (approximately 30 - 60 pages) of the co-factors which will be included in the plan for use by prevention providers who can use the information in preparing requests for funding. The intent of the Committee is that reviewers of applications would note whether the applicant adequately described the issues (co-factors) specific to their target group in the application.

Priority-setting Co-factors with key examples *

Poverty
- financial instability
- homelessness

Biological
- STDs

Psychological
- mental health stressors
- history of child sexual abuse
- history of abusive relationships
- self-esteem
- rape
- social support

Behavioral (other)
- risky partner
- commercial sex workers
- substance abuse
- multiple sex partners
- discordant couples

Lack of Access
- knowledge of services
- language
- low literacy

Social/Cultural
- institutionalization
- perception of susceptibility

Discrimination
- racism
- sexism
- homophobia/transphobia
- ageism
- disability

* This is not meant to be an exhaustive list of examples

Phase IV - Provider-specific information

Phases I and II provide a basic ranking of the behavior groups, and Phase III provides a mechanism to acknowledge and describe the complexities of conducting HIV prevention activities by describing barriers to prevention. Phase IV enables providers to apply the model to their specific target groups. Many providers identify their target groups, not necessarily by the behavior, but by other characteristics such as sexual orientation, ethnicity, or life situation. Within some of the general behavior groups there are populations at increased risk. For example, young gay men are at higher risk than the general category of men who have sex with men. Similarly, commercial sex workers may be at higher risk than the general category of women who have sex with men. Phase IV allows these distinctions to come across and enables the populations with the highest need for prevention to take precedence over populations at lower risk.

Phase IV occurs during the application process. Providers will be given in the plan information about the average frequency of behaviors, relative risk, and the simple Phase I formula (the sum of behaviors times relative risk). It is expected that some providers will have information that indicates that their target group engages more frequently in specific behaviors. The Committee discussed briefly how providers might use this information to re-calculate a specific target-group Phase I score, and thus increase the priority for that target- group relative to the general behavior group. Further discussion is needed to clarify how provider information can be used to adjust priority scores.

Further, Phase IV requires that providers describe the presence and extent of co-factors within their target groups. This description will be part of a needs statement, and the information will come from providers' knowledge of and interactions with clients, as well as any other information available to providers, such as ethnographic studies, needs assessments, and findings from the evaluation plan that is being developed this year.

In the first year of implementing this model, providers will have less information available to them than they will in subsequent years. But over time, with assistance provided by the substantial technical assistance/capacity building contract and findings from the city-wide evaluation, providers will be in a better position to assess and describe more accurately the needs of their target group - both the behaviors that place the clients at risk and the co-factors that increase their susceptibility to HIV or operate as barriers to prevention.

STRATEGIES AND INTERVENTIONS COMMITTEE

Process for Decision Making

In the first year of prevention planning, the plan outlined overarching themes and presented information about strategies and unmet needs. In year two of process, the HPPC's Strategies and Interventions Committee continued the efforts by developing an inventory of interventions and describing cross-cutting themes. This work, which will become a chapter in the HIV Prevention Plan, provides a set of guidelines for the implementation of prevention strategies and interventions. The Committee met two to four times per month for approximately five months. Meetings were facilitated by the Committee's chair. A core group of approximately 10 members attended Committee meetings regularly, and additional HPPC members attended less frequently. AIDS Office staff participated on the Committee. Consultants provided technical support to the Committee.

Each aspect of developing the strategies and interventions chapter required Committee members to make decisions about the kind of information that would be most useful to the community and how to present it. The structure of the document as well as all aspects of its content were discussed and decided by Committee members present at meetings. In general, decisions were made using a nominal group process, which involved open discussion and group consensus.

The Committee drafted descriptions of each intervention and an introduction with cross-cutting themes and recommendations. Shortly after the completion of the first draft of this document, the Committee experienced a major turnover in membership, and new Committee members continued with the task by drafting a section for each intervention that describes applications of the interventions. This shift in Committee composition and the need to orient new members slowed the process for a time as new members reviewed the draft.

Specific guidelines for each strategy and intervention were developed by subgroups of Committee members. Subgroups of two or three people were assigned to each of the strategies and interventions outlined in the document. Consultants compiled the small groups' work into the complete document for review by the entire Committee. The document was revised several times based on Committee discussion. A draft of the chapter was presented to the entire Council for their comments. Comments were incorporated and the subsequent draft was reviewed.

The critical issue that was a source of tension in the Committee, was the question of prioritization. Members tried several approaches to rank or order strategies. A fundamental problem was that interventions are designed for specific target groups, yet the HPPC's priority-setting process was designed around behavior groups. The Committee considered whether to prioritize interventions by the behavior groups, but found that this was not a useful approach. Next the Committee used several meetings, including a day long retreat to attempt prioritization of interventions by a combination of behavior groups and defining characteristics, such as age,

poverty-status, and language. After an intense effort, the members concluded that the results would be of little value to community providers.

In consultation with the community, AIDS Office, co-chairs and consultants, the Committee discussed the purpose of prioritizing interventions. Members expressed concern about a strict prioritization: all felt that of most value to providers would be the detailed, specific guidance developed by the Committee, particularly standards of practice and expected outcomes. Members believed that providers should be allowed the flexibility to develop innovative approaches to prevention and did not wish to limit the interventions that providers could use as long as providers based the intervention on need, sound program design and theory, and acceptable standards and outcomes. The HPPC co-chairs and Committee members believed that providing this guidance would be of more use to the community than would be a prioritization process that strictly met a narrow interpretation of the CDC guidelines. Further, the criteria identified by the CDC (effectiveness, scientific theory, values and norms) were all elements within the Committee's chapter.

The Decisions

Separate Strategies and Interventions

The Committee chose to make a distinction between prevention "strategies" and prevention "interventions." A strategy is an approach to prevention and can be applied across the entire spectrum of possible interventions (such as peer education). Interventions are defined as the type of service a prevention program provides (e.g. individual sessions, outreach, educational workshops). Strategies are discussed separately from the interventions in the chapter.

Describe Cross-cutting Themes

A second decision involved including a number of general recommendations for providers in the chapter's introduction. Discussing the importance of conducting needs assessments, incorporating evaluation in program designs, and using volunteers should be considered with any prevention strategy or intervention, for example. It was the Committee's decision to expand the introduction to highlight these overarching themes that have broad applicability to prevention programs in general. The identified themes include linkages and coordination, training, volunteer use, prevention messages, needs assessment, evaluation, confidentiality and grievance/feedback procedures. These topics are presented as general recommendations for all strategies and interventions.

Behavior Theory Section

The consultants were asked to review the literature and develop a section on behavioral theory and its use in prevention programs. The section should operate as education and guidance for providers who develop new programs.

Information on Individual Strategies and Interventions

In keeping with its goal of creating a useful tool for prevention providers, the Committee developed a format for describing the strategies and interventions. For each strategy and intervention, the guidelines present a definition and description to establish a common language for prevention. Committee members also identified a set of standards of service delivery for each intervention that would ensure consistent quality of prevention services. Expected outcomes for each intervention were also discussed and are outlined in the chapter. Information on effectiveness of the intervention is also discussed, including outcome and cost-effectiveness.

How to Prioritize

A final task of the Committee was to prioritize the strategies and interventions for prevention for specific target populations. In discussing a process for accomplishing this, it became clear that establishing a priority listing of interventions would not be as useful for providers as would an outline of suggested uses and limitations of each of the strategies and interventions. Through group discussion, Committee members developed applicability guidelines that describe the characteristics of those for whom a particular strategy or intervention would be appropriate. The Committee looked primarily at specific characteristics such as financial stability, perception of risk, and lack of social support. Many of the characteristics used by the Committee in its discussions are also co-factors that were used by the Priority-setting Committee. Along with the suggested uses are special considerations, limitations or modifications to the intervention that would be necessary when targeting populations with certain characteristics.

The decision to present suggested uses and limitations of each strategy and intervention is in line with the Committee's goal to provide guidance to the community and to not discourage the use of certain strategies and interventions. The Committee felt it was more important to focus on the standards of service provision and expected outcomes. The descriptions of strategies and interventions are deliberately broad to allow maximum flexibility and creativity on the part of providers to tailor their prevention efforts to the community they are trying to reach in the most effective way. The applicability guidelines should help providers explain their choice of interventions for their target populations.

Results

The final product of the Strategies and Interventions Committee will be the chapter of guidelines for San Francisco's Plan. A draft is attached. There are several sections that are incomplete or missing and they are outlined below.

Outstanding Tasks

- Expand the effectiveness sections for each strategy and intervention. Research data and other information on cost effectiveness, outcome effectiveness, and appropriateness to the social norms of various groups is being gathered and will be summarized.
- Include a section on behavior theory as part of the introduction to the chapter.
- Complete a bibliography for the chapter with consistent citations throughout the text.
- Complete any missing sections for the individual strategies and interventions.

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SF Public Health

HIV PREVENTION PLANNING COUNCIL
MINUTES
December 7, 1995

Members Present:
Jonathan Brown
Rafael Chang
Thomas Lee Eades
Fernando Gomez-Benitez
Natalie Gutierrez
Karen Hart
Jacqueline McCright
Lidia Mena-Hermida
Ana Claire Meyer
Dominic Perez
Joshua Volle
Kiki Whitlock
Hank Wilson
Bobby Wiseman

Members Absent:
Barbara Adler
Rafael Diaz
Ellen Goldstein
Cynthia Gomez
Robert Hays
Valerie Kegebein
Yvonne Littleton
Burton Maxwell
Kerrington Osborne
Les Pappas
Juan Rodriguez
Jay Seward
Susanna Torricella
Phillip Tse

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AIDS Office Staff:
Brian Dobrow
Delia Garcia
Norm Nickens
Tracey Packer

Polaris, Inc./Harder + Co.:
Mary Irvine, Polaris
Lyn Paleo, Harder + Co.

Guests:
Mike Allison, The Support Center
Anne-Marie Benedicto, Asian AIDS Project
Elizabeth Davis, Real Alternatives Program
Jonathan Ellen, City Clinic / STD/HIV Prevention Training Center
Alice Gandelman, City Clinic / STD/HIV Prevention and Control Program
Vince Sales, Asian AIDS Project
Fred Sonnenberg, STOP AIDS Project
Wendy Wolf, City Clinic / STD/HIV Prevention and Control Program

1. WELCOME & INTRODUCTIONS
Completed. Ana Claire convened the meeting at about 4:15pm. She announced that Valerie Kegebein was out sick, and began the introductions around the table.

2. MINUTES OF 11/09/95
Postponed. The minutes could not be approved without a quorum present. Once a quorum was achieved, the minutes were approved without exception.

3. ANNOUNCEMENTS
Completed.

- The HPPC is requested to support the AIDS Office application for 43-46 million dollars in Ryan White CARE funds, which maintain all Title One service providers in the city. Brian read Valerie's draft letter (enclosed) supporting the application.

- Dr. Jon Ellen spoke briefly to request a letter of support from the HPPC for a symposium to be put on by the Prevention Training Center. The seminar involves a collaboration between researchers and community people, and was developed by the Training Center in response to an RFP from the CDC for conference funding. The application is due by the end of next week.

- Tracey announced that the AIDS Office had awarded the TA (technical assistance) contract for organizational development and capacity-building to a collaboration of agencies (the Support Center, Harder + Co., Communication Sciences, and Polaris, Inc.). Delia Garcia, in attendance at this meeting, is the AIDS Office program manager on that contract. The STD/HIV Prevention Training Center will also provide technical assistance.

  The first step of this contract for TA on organizational structure, program planning, implementation, and evaluation will be to conduct a needs assessment of CBOs, DPH programs, and the AIDS Office itself. The CBOs will include prevention agencies both funded and not funded through the AIDS Office. Notices have already been sent out about this upcoming process. The results of the needs assessment will be presented to and discussed with the agencies assessed.

- Alice explained that for the last five years the STD/HIV Prevention Training Center has been providing planning and evaluation courses, among others. For this TA collaboration, the Center will offer courses in planning, intervention, and evaluation. Alice said that the Center hopes to include real-life examples. The facilitators can focus on the strategies and interventions that have been chosen by providers in the course.

4. DISCUSSION (of the technical assistance plan of action):
Tracey asked members for suggestions as to the criteria determining which agencies, following the needs assessments, should receive TA in organizational development. Hank suggested that TA should be provided partly according to who requests it. Thomas Lee expressed concern that the letter about TA was "the cart before the horse," in that few providers know enough yet about the HPPC process to know whether or not they will need TA to comply with the Plan. Karen asked if the TA was supposed to help agencies get CDC funding. In response, Tracey stated that the ultimate intent of the TA is to make HIV prevention as effective as possible; but it also helps agencies to get on an even playing field for funding.

Mike Allison explained that, originally, only 12 agencies were to be assessed by the TA collaboration, so that TA could be offered to those needing it among the 12. Now, Valerie is opening up the assessment to all HIV prevention agencies currently or formerly under contract with the AIDS Office for education and prevention funds. At the end of the first phase (the assessment), the TA collaboration will have an opportunity to discuss with individual agencies, the HPPC, and the Co-chairs how best to use the resources available on this contract. They may get distributed among 12 agencies, or get spread around to others as well.

Ana Claire asked that the group present focus today on setting criteria to filter out the 12 agencies which would be receiving intensive TA. Dr. Ellen agreed with Thomas Lee, that the people in greatest need of TA may not know enough about the Plan and the application process to ask for it. Mike Allison responded that there will be a meeting in January about the needs assessment, and all those who might be interested will be invited. Agencies will have a chance at this meeting to see what is involved in the needs assessment.

Hank suggested finding out which agencies already receive TA and which ones either get assistance for evaluation or have evaluation mechanisms in place, in order to avoid a duplication of TA. He added that the "gaps in services" which the TA contract intends to remedy should be defined by the agencies themselves, as well as by the AIDS Office.

Jacqueline asked about whether the AIDS Office could use the monitoring reports submitted by funded agencies, to measure and locate their needs for TA. Rafael Chang asked what was the time frame for the completion of the assessment. Mike Allison said that the protocols for the assessment would come out in mid-January. Within 6 weeks of the release of protocols, the assessment should be completed (by the end of February).

5. DISCUSSION (of the State funding allocation, requiring a letter of HPPC support):
Brian Dobrow gave a report on the future funding of agencies that have received direct State funding for HIV prevention in the past. He explained that the AIDS Office will apply for funding to support the programs that were directly funded by the State previously. The California State Plan did change the way that funding is distributed to prevention providers -- leaving local health jurisdictions to divide up block grants from the State for HIV prevention. The funding amount has not yet been increased, except slightly for Los Angeles and San Francisco (which is receiving 10% more, for a total of $1,630, 200.00). At least through the 1996/97 funding period, the DPH will continue to fund at the same level those organizations that received DPH or direct State funding in the past. This was decided because time has grown too short to issue RFPs this year for the funding to start at the beginning of next year. *(Update from Valerie: The Council has already discussed not putting out any RFPs until 1996 for 1997. It does not seem prudent to issue any RFPs until a framework for how RFPs will be standardized is established through committee activities that will take place next year.)*

The State wants a scope of work for 1996/97, a preliminary budget (showing all contracts for the agencies), a letter of HPPC concurrence with the plan to allocate money at the same levels as in the past (the sole-source approach), a copy of the current San Francisco HIV Prevention Plan, and an indication of how this proposed use of State funds complements the Plan. The AIDS Office is continuing to fund all agencies at the same levels until RFPs can go out for prevention funding. Brian pointed out that the agencies in question basically already follow the Plan.

The preliminary budget shows how funding will be allocated to the AIDS Office, to YPEP, and to CBOs. Brian noted that money has been set aside for a proposed AIDS Office study responding to established HPPC priorities. This proposed study in the transgender population has been designed to gather additional information, basic research, quantification, and epidemiological data in areas which have been lacking in available data.

Brian read a paragraph on each of the 10 projects previously funded by the AIDS Office or directly by the State (there are five of each). The paragraphs were extracted from summaries provided to the AIDS Office by these programs, for eventual review at the State level. The paragraphs briefly

describe the population(s) targeted and the intervention(s) used by each agency. The NTFAP is listed as the fiscal intermediary for the Native American AIDS Project; the Haight-Ashbury Free Clinic serves as the fiscal agent for the Women's Needs Center; the AIDS Office directs YPEP (Youth Prevention Education Project); and the RAP (Real Alternatives Program) and Instituto Familiar de la Raza carry out prevention activities collaboratively. The total application, including the brief program descriptions, will be submitted to the State on December 14th.

Hank asked what had been the consultation process for the transgender research project; he wanted to know if members of the transgender community had been involved. Brian replied that that process had not yet begun, but will happen. He said that the project follows from Council discussions and directions that took shape in January of this year (1995). Hank argued that the transgender community should have been involved from the conception of the research project; this way, money could have been saved for the more creative purposes and ideas coming out of the transgender community. *(Note from Valerie: There have been a number of discussions with members of the transgender community at HPPC meetings. Through those exchanges, a basic outline for the foundation of a research project was developed in response to the availability of State monies. The AIDS Office has every intention of meeting with members of the transgender community, in order to further define the design of the research study.)*

Jonathan asked if the NAAP is the only project of the NTFAP funded with State money. Brian clarified that this is the case, although the NTFAP houses several prevention projects.

Jacqueline asked if AIDS Office staff would meet with members of the transgender community before December 14th. Brian responded that this meeting would not actually take place before the 14th (when the application is submitted). He added that the application does not set in stone the details of the study.

Rafael asked if the 1.6 million in grant money from the State to San Francisco would be folded into the city amount for 1996/97. Tracey responded that, in a sense, this was the case -- the DPH is on the same fiscal year as the State, but the CDC is on a calendar year. Rafael then asked if the AIDS Office had reviewed the monitoring reports from the State direct-funded agencies. Tracey mentioned that these five agencies, which would now be funded by the AIDS Office, include the AAP, STOP AIDS Project, the Haight-Ashbury Free Clinic (for the Women's Needs Center), the NTFAP (for the NAAP), and RAP/IFR. At this point, Rafael suggested that the AIDS Office also review the monitoring reports from these agencies. *(Note from Valerie: The State infrequently conducts monitorings of their agencies; however, quarterly reports completed by the agencies can be reviewed.)*

Thomas raised a question about the requirement developed a couple of years ago, that anyone wanting to secure a State contract would have to join the county collaboration. There were a few agencies, like the NAAP of the NTFAP, which chose not to join. (For the NAAP, the choice related to operating as an East Bay program.) Thomas wondered how such a choice would affect the funding coming up now. Brian said that funding for 1996/97, at least, would not be affected. *(Update from Valerie: Further discussions with the NTFAP, regarding the scope of work of the NAAP, will take place in the next few weeks.)*

Fernando wanted to know how the current HPPC timeline would affect the group process. Tracey reminded those present that the current timeline does not diverge from the Council's original plan. The RFPs will still be developed by the spring/summer of 1996, to provide funding for 1997; the

Council has to delay six months for the State portion, which is provided on a different funding cycle from the CDC portion.

Jacqueline spoke up to say that she thought the planning group had intended to stop directing money to agencies based solely on the fact that they have received it in the past. She recommended that the AIDS Office look at the agencies' monitoring reports before turning in the application to the State this month. Tracey pointed out the limitations due to the State-imposed deadline for this application. The AIDS Office has concerned itself largely with preventing gaps in services that might otherwise result from the timing of the RFP. *(Note from Valerie: The Council previously discussed continuing funding for all prevention organizations through 1996.)*

Hank asked a question about item A on the budget, which led Tracey to give this clarification: Item A accounts for personnel of the AIDS Office. Some of these will be working on the transgender study; but many of them are working on program management, coordination of health education activities, and the Sex Club Ordinance. Rafael asked what would be the actual amount earmarked for the transgender study, if not the full $252,321.00 attached to budget item A. Tracey and Brian answered that that amount would come to something under half of the total (about $125,000.00).

Just before the Council vote, Kiki asked whether a vote of approval would indicate approval of the estimated amount set aside for the transgender study. Brian said that the packet going to the State would include a letter of intent with a detailed work plan, a budget, and a letter of HPPC concurrence. The State will review letters of intent in January, along with the local HIV Prevention Plans. Their response will come back to the Council some time in March. Brian added that the AIDS Office would review available program reports. Thomas described the application deadline as a last hurry-up push from the State. As he put it, a block grant means that the county will decide how best to meet the overall prevention planning goals with the available funding, once that funding is received.

Rafael made a motion to concur with the AIDS Office letter of intent. He added the following stipulations: before this comes to Council in March, the AIDS Office will

- review all State and city monitoring reports,
- bring transgender community members into a meeting to discuss the proposed study, and
- specify the budget allocation for the transgender research project.

The Vote:*
12 approved
0 objected
1 abstained
The motion passed.

Next the Council voted on whether to give a letter of support to the AIDS Office application for Ryan White CARE funds for the City and County of San Francisco.

The Vote:
13 approved
0 objected
0 abstained

* thirteen members voted at this meeting

The motion was unanimously approved.

Then the Council voted on whether to issue a letter of support for funding of the symposium outlined by Dr. Jon Ellen.

The Vote:
11 approved
0 objected
2 abstained
The motion passed.

6. LAST ANNOUNCEMENTS:

- Ana Claire announced that on December 14, the Council will meet to take care of a little business (see the attached agenda), after which there will be a celebration. The two Subcommittee chapters are in the process of being written in their final forms. They will be reviewed and put up for Council vote at the following (January 11) meeting.

- Jacqueline asked about the due date for new member nominations. The deadline is December 22.

- Lyn gave an update on the co-factor piece for the Plan. Harder + Co. staff are finishing this piece for inclusion in the Priority-Setting Subcommittee chapter. Subcommittee members will have a chance to revise and approve this section before it goes to Council. A meeting time for early January will soon be posted.

7. PUBLIC COMMENTS:

- *Vince Sales* spoke to say that he was disturbed by the HPPC process. He had been asked to come to this meeting -- with the explanation that his contract (the Asian AIDS Project contract) would be discussed, and it was in his best interest to appear. He said he was unsure of why he was expected to come in the first place, and his presence in the meeting had gone unrecognized by the HPPC. He was upset that members had discussed the ten (previously State-funded or AIDS Office-funded) agencies, without ever asking their representatives to speak. He felt that members were insensitive and dismissive in their discussion of whether these agencies could meet the requirements of the Plan or whether their "weaknesses" should be considered before re-funding.

- *Anne-Marie Benedicto* expressed regret that the Council had not heard from these agency representatives, since their attendance presented an opportunity to have questions answered about organizational capacity and compliance with the objectives of the Plan.

In response to these comments, Thomas said that members had not been notified that people were asked to come to the meeting, and were not made aware of their purpose in being there once they arrived. He agreed with Vince and Anne-Marie that this represented a serious gap in communication, and suggested that a letter of apology go out to the guests from the AIDS Office.

Joshua pointed out that the Council has previously encountered such difficulties with including in its discussions those community members who are closely involved with the issues on the table. He proposed that the Council re-visit its process for meetings, since its process has not been working for members or guests.

Fernando asked that, aside from the larger process issues, Council members at least be told how a meeting will be conducted (who has been invited to do what, etc.).

Natalie argued that everyone needs to be included in the meetings; some of the agencies discussed on this occasion were also represented by particular Council members. She said that the monitoring discussion could have happened in a different way and at a different time, and she apologized for the Council.

Kiki added that it had been distressing for the transgender community to go through what it went through just to get heard and seen by the Council. She called the Council's process of making decisions for communities without their participation "ridiculous and disempowering." She pointed out that there are no "experts" on other folks' issues.

Jonathan expressed his hurt at the comment that members had been dismissive of the agency representatives. In his view, regardless of whether there are guests in the room, Council members should be more conscious of what they say and how they say it.

Hank requested that the agenda for the next meeting include a time for constructive discussion of the HPPC process. Ana Claire said that issues of HPPC process would be addressed at length in the By-laws and Membership Committee next year.

Attachments to these minutes:

- Valerie Kegebein's letter of support (from the HPPC and the HIV Prevention Planning, Policy, and Health Education Section of the AIDS Office) for the AIDS Office application for Supplemental Grant Funds under Title I
- HPPC letter of support for the STD City Clinic's application for the funding of a symposium: "Bridging the Gaps Between Theory, Research, and Practice"
- HPPC letter of support for the AIDS Office preliminary budget and scope of work regarding the State funding allocation

Next HPPC meeting: December 14, from 4 to 6pm at the First Unitarian Church -- 1187 Franklin

12/14/95

HIV PREVENTION PLANNING COUNCIL MEETING

December 14, 1995
4:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ana Claire Meyer
Valerie Kegebein
Kerrington Osborne

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Agenda

1.	Welcome & Introductions	Valerie Kegebein	4:00-4:05 PM
2.	Minutes of 11/09/95	Valerie Kegebein	4:05-4:10 PM
3.	Announcements	Valerie Kegebein	4:10-4:15 PM
4.	Behavioral Study Update	Valerie Kegebein	4:15-4:20 PM
5.	Strategies & Interventions - Final Chapter	Ana Claire Meyer/Tracey Packer	4:20-4:40 PM
6.	Public Comments	Ana Claire Meyer	4:40-4:50 PM
7.	Holiday Celebration	All	4:50 -???

Up-Coming Meetings

HPPC - January 11, 1996, 4:00 - 6:00 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary).

HAPPY HOLIDAYS AND HAPPY NEW YEAR

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SF Public Health

HIV PREVENTION PLANNING COUNCIL
MINUTES
December 14, 1995

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Members Present:
Barbara Adler
Rafael Diaz
Christine Edwards*
Ellen Goldstein
Natalie Gutierrez
Robert Hays
Valerie Kegebein
Yvonne Littleton
Jacqueline McCright
Ana Claire Meyer
Kerrington Osborne
Dominic Perez
Susanna Torricella
Joshua Volle
Kiki Whitlock
Hank Wilson

AIDS Office:
Betty Chan-Lew
Brian Dobrow
Lyn Fischer-Ponce
Delia Garcia

Members Absent:
Jonathan Brown
Rafael Chang
Thomas Lee Eades
Cynthia Gomez
Fernando Gomez-Benitez
Karen Hart
Burton Maxwell
Lidia Mena-Hermida
Les Pappas
Juan Rodriguez
Jay Seward
Phillip Tse
Bobby Wiseman

Polaris, Inc./Harder + Co.:
Mary Irvine
Lyn Paleo

Guests:
Patrick Forte

1. WELCOME & INTRODUCTIONS
Completed. Valerie welcomed and introduced Betty Chan-Lew, who does a great deal of administrative assistant work for the AIDS Office and, more specifically, for the HPPC. She has contacted most of the members at one time or another to get their phone numbers, faxes, addresses, etc.

2. MINUTES OF 11/09/95
Approved at the previous meeting. The minutes from 12/07/95 had not yet been completed and mailed, and so could not be approved.

3. ANNOUNCEMENTS
Completed.

- *Valerie:* Presentations for the Reggie System will be held in the AIDS Office on three dates in January (see the enclosed letter with details). The Reggie System, which will largely and initially be used for CARE contracts, allows client data to be entered in a standardized form and shared between agencies, while maintaining client confidentiality and setting some information aside for internal agency use only. This centralized system should assist CARE-funded providers with the coordination of services and referrals.

* Kristine is a new Council member, attending her first meeting.

The Public Library is offering online (Internet and WWW) search trainings (see enclosed). (Hank asked when these trainings would be taking place; and Valerie responded that there were two scheduled for December, and they should still be ongoing after this month.)

- *Yvonne:* With some prompting from Valerie, Yvonne admitted to having completed her BA. Yvonne returned to finish her degree after being out of school for 26 years.

- *Valerie/Kristine:* There have been two new appointments to the Council. Valerie introduced Kristine Edwards, who is one of the two new members. Kristine explained that she works for the Forensic AIDS Project, doing counseling, testing, and education in San Francisco and San Bruno jails. While the Project also offers early intervention for people with HIV, she primarily works with the prevention side -- conducting educational sessions with groups of 10-50 people and providing testing and counseling services.

- *Kerrington:* The deadline for HPPC membership applications is approaching (December 22), so members should quickly submit their nominations or contact the CBOs they think should definitely have Council representation, to remind their staff to apply. There have been 28 nominations made so far. This time, the Council is asking nominators for more information on their nominees -- specifically, information about experience with planning and HIV prevention.

4. BEHAVIORAL STUDY UPDATE

Completed.

In an update on the study of women who have sex with men who have sex with men, Valerie introduced Delia Garcia as the field coordinator. Geoff Henderson, who first described the study to members in a Council meeting months ago, is the project director. The team of field interviewers will probably be hired by the first of the new year. The study is currently at the stage of questionnaire design and refinement. In the beginning of January, an advisory committee will be re-convened to make last revisions to the questionnaire before submitting it to the Human Subjects Review Board.

One field interviewer is mapping the city, by neighborhood and by venue, for the massive outreach and recruitment process which will be necessary to achieve the goal of 200 respondents, in this relatively hidden and disconnected population. Thus far, there have been organized outreach efforts for the study at the Women and HIV Conference, the Castro Street Fair, and the Bisexual Coalition. The project also now has a dedicated phone line for interested women to call. Already, twelve eligible respondents (meaning that they are women 18 or older who have had sex with a man who has sex with men in the past three years) have contacted the project staff using this line.

5. LINKAGES STUDY UPDATE

Completed.

The Linkages Study will examine the systems by which clients are referred from counseling and testing sites to other services. The brief update provided by Valerie and Lyn Fischer-Ponce revealed that this study will use the STD City Clinic as its pilot site. Currently, the research staff are collecting documentation of referrals and following up on those clients that did not comply with the referrals.

Both the Linkages Study and the Women's Behavioral Study are scheduled for completion, including full data analysis, by the end of August 1996. This deadline will allow the AIDS Office to begin working on the next studies suggested by the HPPC priorities, depending on the availability of State funds.

DISCUSSION
Yvonne asked if the women's survey was largely relying on flyers or if the staff were going out to talk to people about it as well. Valerie responded that the project had ads in community papers and was doing community outreach to agencies. Both in-person and "passive" (flyers, ads, etc.) methods of recruitment are being employed.

6. STRATEGIES & INTERVENTIONS -- FINAL CHAPTER BRIEFING
Completed.
Tracey Packer was absent, so Ana Claire quickly brought the Council up to date on the Subcommittee's progress. She said that there is not much new information to present, but that the chapter is being written now. It will be sent out to the full Council by December 22, so that it can be put up for a final vote of approval at the January 11 HPPC meeting. ***All comments and suggested changes must be faxed to Tracey Packer at the AIDS Office by January 2 (or mailed to her there for delivery by the same date).*** These written responses will then be considered at the Subcommittee meeting scheduled for January 4. Only those comments given to Tracey by January 2 can be incorporated into the chapter which will be submitted for Council approval on January 11. Any changes (beyond slight revisions in the wording) that the Subcommittee agrees to make after the December mailing will be brought to the attention of the full Council at the January 11 meeting.

7. DISCUSSION OF PROCEDURE FOR PUBLIC COMMENTS
Completed.
Ana Claire turned the attention of the Council toward the issues and incidents that had arisen around the presentation of public comments at HPPC meetings. She reviewed members' and guests' suggestions that public comments precede the voting on any issue, that public comments be incorporated so that they can more effectively influence the way Council business is conducted, and that the meetings include a comfortable space for community people to bring their concerns to the Council. She proposed the solution of moving public comments to the top of the meetings, before voting takes place.

Hank argued that the public should be able to participate in the discussion of every topic on an HPPC agenda. He said that a bounded section for comments at the beginning of each meeting would not allow sufficient involvement or consideration of the public. He described a process in which any member of the public could address each agenda item in turn, speaking several times during the meeting. This system, Hank explained, would be more realistic and lead to more valuable public comments than a system which requires guests to compress all of their concerns into a single statement (whether at the beginning or the end of a meeting). He stressed the importance of quality participation, as opposed to token participation. Public comments should present an opportunity for the Council to gain from the expertise of attending community members on particular issues. Hank expressed his conviction that, for public participation to be meaningful, it would have to occur as part of the natural flow of the agenda. He also pointed out the importance of setting the stage for community people to participate at meetings -- by, for example, introducing the topics to be addressed at each meeting, along with some background information. This approach would get the public and the Council members "on the same page," encouraging relevant and focused contributions to discussions.

Kerrington responded that opening up each agenda item to public comments would require members to commit to spending much more time in HPPC meetings. He maintained that public comment can be meaningful within a time limit, as long as it's done right (e.g., with an introduction of the topics pertinent to each meeting). In his view, though, the most meaningful public comments take place in the Committee setting. Council meetings have been designed for conducting the business of the HPPC, in a way that is informed by public participation. Whereas the Subcommittee meetings can provide forums for extensive public comments, an engagement of the public on every Council agenda item would not allow for completion of Council business in the manner that members expect. Kerrington closed by saying that the presentation of topic-by-topic public comments could actually hold up the agenda and become disruptive -- but the Council could discuss the option of setting aside certain meetings for public comments.

Valerie asked Susana how the State meetings handle public comments. Susana explained that it has a very different system, based on two-day meetings. On the first day, public comments are given in the morning; and, on the second day, they take place in the afternoon. Each person's public comments are kept to a three-minute time limit. Later, members of the public sit together at a table, where members of the CPWG and Committees can ask them questions and continue discussions begun in the formal meeting. Valerie asked if the State specifies particular topics on which it will hear public comments. Susana responded that, instead, the group distributes an outline before each meeting, to focus people on the specific topics to be addressed.

Ellen spoke in agreement with the spirit of Hank's suggestion. She said that the confinement of public comments to the end of each meeting gives them a token status and evokes an atmosphere of hostility and disrespect between the Council and the public. The most constructive vehicle for public comments would be interactive, would take an earlier position in the meetings, and would be able to speak to the specific points brought up with regard to agenda items. While Ellen agreed with Kerrington that the best work seems to happen at the Subcommittee level, she objected to structuring the full Council meetings in such a way as to disable public comments.

Hank said that the public comments at the State level had worked well. Not only were there two separate opportunities to give comments at the meetings, but there was a chance to answer questions and give clarifications afterward. The State created an opportunity to use the resources surfacing in the community. On the subject of overburdening the agenda, Hank said that he didn't anticipate this happening as a direct result of item-by-item public comments. He agreed that there needs to be some process to make public comments go smoothly, but emphasized that there has to be some vehicle to let any concerns, misconceptions, and/or frustrations surface.

Joshua stated that, while there has to be some time limit for comments, he liked what Hank had said. He added that the agenda for each meeting should be advertised and the public encouraged to participate, especially at the Subcommittee level. He pointed out the need to be more respectful with community members at Council as well -- by finding a way actively to use their input, rather than tokenizing them and letting them speak only after the Council has voted.

Ana Claire asserted that the whole purpose of forming the Council was to get community input on the changes to be made in the provision of local prevention services. She identified herself as a community member, who had joined the HPPC in order to give community input. She noted that the language people had been using about public comments propped up an artificial distinction between providers on the Council and "community people." While she supported the idea of a

question-and-answer session between members and guests, she expressed concern that it would be difficult to run a meeting with public comments following every agenda item.

Kiki stated that, when you don't give the public an opportunity to speak -- especially on the issues which have particular implications and repercussions for their community -- you do a disservice to the whole process, aside from being disrespectful and disempowering. Kiki dispelled the idea that the public would insist on talking about each agenda item, explaining that what mattered to the public and should matter to the Council was the opportunity for them to speak on issues that are close to the community. She recognized that there needs to be some protocol around comments, but assured the Council that it can't hurt anyone to hear people out.

Valerie noted that the type of discussion that was currently taking place in the Council meeting could be incorporated into the activities of the Membership and By-laws Committee. The Committees planned for next year include:

- Resource Allocation and Inventory
- Membership and By-laws
- Epidemiology and Needs Assessment
- Goals, Objectives, and Linkages
- Program Evaluation and Research
- Technical Assistance

Valerie let members know that they can sit on more than one of the above if they have enough time, and that the descriptions of all of the Subcommittee activities and objectives are about to be issued.

Rafael commented that it would be helpful to have a short set of meeting evaluation questions to give to the attending public, so that the Council can get a more direct view of guests' level of satisfaction with the way meetings are conducted. Hank added that it would be useful to check with guests to see if they already know what the process is -- and to fill them in at the outset if they don't. This measure would give the public guidance and confidence as to how they may participate. He referred to the last meeting (December 7), where he said most people didn't know what was supposed to be happening. In closing, he warned that the Council can't afford to skimp on the opening introductions, which also give people a clue as to what are the issues at hand and whose interests are involved.

Kerrington reminded those present that January 11 will mark the last meeting of this Council (or this session of the Council). For this reason, it is an extremely important meeting for everyone to attend. Aside from making the final decisions about the two chapters for the Plan, the Council members will be facing choices about which new Subcommittees to join.

Lyn Paleo mentioned that the task of writing the Priority-Setting chapter has become extremely demanding, and that she would talk to Joshua about the amount of time available for Subcommittee members to read through the document and give feedback before its submission to the full Council.

<u>Note from Lyn:</u> The Priority-Setting chapter will be delivered by messenger to Priority-Setting Committee members on January 2. Please review the draft. There will be a Committee meeting on Monday, January 8, from 3-5pm at the AIDS Office. Please attend this meeting to give your comments on the draft. If you cannot attend, please give your comments to another Committee member or to Lyn (Phone: 522-5400/Fax: 522-5445). Do not wait until the full Council meeting to make your comments. The draft will be mailed to all other HPPC members by January 8. At

the January 11 Council meeting, there will be a final review and (hopefully) adoption of the chapters.

Valerie asked if there were any public comments, and none were offered. She then invited general comments from anyone wishing to make them -- about the close of the year or any other topic. Since no one responded, the Council adjourned and moved on to the celebration.

Next Council Meeting: January 11 from 4-6pm at the First Unitarian Universalist Church, 1187 Franklin. Again, this is a critical meeting -- please make every possible effort to attend.
Next S. & I. Meeting: January 4, from 4-6pm at the AIDS Office. Come to discuss last changes.
Next P.-S. Meeting: January 8, from 3-5pm at the AIDS Office. Come to discuss last changes.

HIV PREVENTION PLANNING COUNCIL MEETING

January 11, 1996
4:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ana Claire Meyer
Valerie Kegebein
Kerrington Osborne

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Please bring: Entire Package

Agenda

1.	Welcome & Introductions	Kerrington Osborne	4:00-4:05 PM
2.	Minutes of 11/09/95	Kerrington Osborne	4:05-4:10 PM
3.	Announcements	Valerie Kegebein/Members	4:10-4:15 PM
4.	Priority Setting	Joshua Volle/Lyn Paleo	4:15-4:30 PM
5.	Strategies & Interventions	Ana Claire Meyer/Eden Tanovitz	4:30-4:45 PM
6.	Break		4:45-5:00 PM
7.	Closure/Awards	Co-Chairs/Co-Chairs	5:00-5:30 PM
8.	Next Steps	Valerie Kegebein	5:30-6:00 PM

- Committee Overview
- New Member Orientation Plans
- Meeting Places

Up-Coming Meetings

HPPC - February 8, 1996, 4:00 - 6:00 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary).

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HIV PREVENTION PLANNING COUNCIL
MINUTES
January 11, 1996

Members Present:
Barbara Adler
Thomas Lee Eades
Christine Edwards
Ellen Goldstein
Cynthia Gomez
Fernando Gomez-Benitez
Natalie Gutierrez
Robert Hays
Valerie Kegebein
Yvonne Littleton
Jacqueline McCright
Lidia Mena-Hermida
Ana Claire Meyer
Kerrington Osborne
Les Pappas
Dominic Perez
Zwazzi Sowo
Joshua Volle
Kiki Whitlock

Members Absent:
Jonathan Brown
Rafael Chang
Michael DeMayo
Rafael Diaz
Karen Hart
Burton Maxwell
Juan Rodriguez
Jay Seward
Susana Torricella
Phillip Tse
Hank Wilson
Bobby Wiseman

Guests:
Connie Amarathithada, CSEARR
Tamara Ching, consultant
Maria Rinaldi, IFR
Cianna Stewart, Living Well Project

AIDS Office Staff:
Brian Dobrow
Mitch Katz
Norm Nickens
Tracey Packer
Mike Pendo

Harder + Co./Polaris, Inc.:
Mary Irvine, Polaris, Inc.
Lyn Paleo, Harder + Co.
Eden Tanovitz, Harder + Co.

1. WELCOME & INTRODUCTIONS
Completed. Kerrington convened the meeting at 4:20pm, and those present made brief introductions.

2. MINUTES OF 11/07/95 AND 11/14/95
Completed. The minutes were approved without exception.

3. PUBLIC COMMENT
Completed.

- Cianna Stewart addressed the omission of *biphobia* from the co-factors under the Discrimination category in the Priority-Setting Chapter. She described herself as a long-time bisexual activist in the U.S. and in this city, and spoke about some of the HIV-related issues that are specific to bisexuals. In working with communities of color (particularly Asian/Pacific Islander communities), she has observed that many bisexual men who have wives or female partners have difficulty coming out to those partners about their involvement with men. At the same time, they may not be telling case workers that they

are married or have female partners. These men are also challenged in getting what they need from men's HIV support groups, where they may experience biphobia and a resistance to hearing about relationships with women.

Cianna also mentioned her participation in a San Francisco coalition which found that people who are having sex with members of more than one gender have to go to more than one agency to get appropriate materials on HIV prevention. There is no single pamphlet or document, she said, which deals with the sexual practices of bisexual people. When there is no funding for bisexual-specific services or pamphlets, people having sex with men and women are required to go into a combination of straight and gay service environments to find information addressing the range of their activities.

Finally, Cianna pointed out that the chapter notes the recent decision in San Francisco to include "gender identity" as a legally protected Human Rights Commission category, and links this decision to the greater role of the San Francisco transgender community in the HIV prevention planning process. Since bisexuals have also gained recognition from the Human Rights Commission as a legally protected group, Cianna argued that they should likewise be included in the priority-setting process and document.

When Ellen asked if there were any particular places in the document where information about bisexuals and HIV could be inserted, Cianna responded that there should be a separate paragraph on biphobia in the co-factors section. Biphobia is not covered under the rubric of homophobia, she explained. Kiki mentioned that biphobia was included in the priority-setting process initially, but had since dropped out. She agreed with Cianna that there are HIV issues specific to bisexual-identified individuals. Cianna followed up on Kiki's comment to say that these issues apply not only to bi-identified individuals, but to those whose behavior is bisexual. Lyn expressed her appreciation of the points raised, and said that she would use them to form a section on biphobia in the Priority-Setting Chapter.

4. ANNOUNCEMENTS

Completed.

- Valerie announced that the AIDS Office has engaged Kathleen Roe to do the Year II and Year III evaluations of the San Francisco planning process. She distributed a short survey form to members around the table, and explained that the forms should be filled out and returned at the end of the meeting, for use by Kathleen Roe.

- Valerie also let the Council know that Hank Wilson had wished to attend this meeting, but could not because his mother passed away.

DISCUSSION:

Bob asked about the choice to keep Kathleen Roe as the evaluator of the planning process. He was concerned about the quality of the Year I Evaluation, and gave the example that some members' comments were left out of the report.

Valerie responded that she is still expecting a final draft of the Year I report, which should include the information from all interviews conducted with Year I members. She added that, in some cases, Kathleen Roe had assimilated similar comments into single statements. Valerie expressed respect and liking for Dr. Roe's work, and said that there will be an

opportunity for outgoing and continuing Council members to participate in informing the evaluation design this time.

5. PRIORITY-SETTING

Completed. Joshua mentioned that the Subcommittee had met on January 8, and had made a few more changes to the draft. He explained that the underlying assumption of the Committee has been that the document represents a fluid and ongoing process. The epidemic, the Council, and the larger population will continue to change; and the content of the chapter will have to change and expand accordingly. At this point, however, the Subcommittee and Harder + Co. have folded about as much information as they can into the chapter.

Joshua explained the two sections of the chapter, as follows:

- Section 1. gives an overview of the first year Council's process and the second year Subcommittee's process for priority-setting -- the decisions made, the changes initiated, and the four phases chosen for prioritization.
- Section 2. offers a full explanation of all the co-factors for which Harder + Co. could find literature. The research summaries are organized in such a way as to answer the questions
  (a) How strong is the connection between the co-factor and HIV risk?
  (b) How does the co-factor increase risk? and
  (c) Who has the co-factor?

  This section also has an introduction explaining some of the technical language used in the research and in the chapter.

Lyn informed the Council of changes discussed at the January 8th Subcommittee meeting:

- Lyn is adding information on the co-factors which were not described in the last draft (*risky partners, mental health stressors, self-esteem, and institutionalization* -- as well as the key example of biphobia under *discrimination).* Short new pieces on each of these co-factors will be included in the upcoming draft of the chapter.

- The pronoun "we" will be replaced, in all places it appears in the text, with a description of the group to which it refers, such as the HPPC or the Priority-Setting Subcommittee.

- All typos will be fixed, and the Table of Contents will be corrected to reflect actual page numbers of individual sections.

- The explanation of terminology used in the co-factors section will be revised for greater accessibility.

- The chapter will include a clarifying statement about the choice of terms used to describe particular ethnic groups (i.e., that the terms were taken from the original studies cited).

- The first matrix for behavior groups (shown in the last draft on page 13) will be altered so that the 'w's are all changes to 'f's -- reflecting the Council's decision to talk about males and females (thus including youth), rather than men and women.

Lyn explained that the execution of these changes will complete the priority-setting work for now. However, it continues to be subject to changes and additions. Harder + Co. will keep a file of

research articles collected and donated by providers in 1996. Then applicants responding to the RFPs can search this file for the information they need to discuss co-factors pertaining to their target populations. This may save some providers the trouble of having to do their own research on co-factors. The Priority-Setting Chapter will be included in the 1996 Plan. The 1997 Council will probably want to review the priority-setting process, and can use this chapter as a foundation.

DISCUSSION

Bob asked why age was not given as a co-factor, when his research has consistently shown age to be critically important to HIV risk. Lyn reviewed that, at one of the last meetings, a vote had been taken on this issue. The decision was to describe age differences for HIV risk as fully as possible throughout the document. The chapter summarizes studies which give comparisons by age. Joshua added that the Council had reached an agreement that age in itself does not constitute a co-factor, but tends to coincide with other co-factors (such as poverty, substance use, and discrimination). Cynthia brought up the connection between this decision and the decision not to make ethnicity a separate co-factor; the Council wanted to be consistent in its focus. Cynthia also pointed out that youth can coincide with a higher frequency of certain acts, as well as with other co-factors acknowledged in the chapter. Providers can make the adjustment to a youthful population's basic score, then. However, she said it would be misleading to represent all youth as being at higher risk.

Ana Claire spoke to say she had brought Cianna in to address the need for a section on biphobia. She was upset to learn that this key example, which the Council had voted to adopt at the November 9th meeting, had since been dropped. She had done her own writing for this section, and took this opportunity to read her piece to the Council. She requested that it be included in the chapter, and gave a copy to Lyn.

Kiki asked if she could write a re-draft of the first paragraph under Appendix C (p. 87), on risks for transgendered persons. She felt that a more inclusive and more appropriate definition was needed for transgender identities. Lyn agreed to the re-draft by Kiki, and they arranged for it to be faxed to Lyn by Friday, January 19.

VI. STRATEGIES & INTERVENTIONS

Completed. Ana Claire presented the changes that are being made to the draft Strategies & Interventions Chapter:

- The behavioral theory section will be completed, with information on Social Networks/ Social Support Theory, Diffusion of Innovations, and Social Marketing Theory.
- The effectiveness data for Counseling, Testing, and Referral is being updated.
- A preliminary statement will be written into the general recommendations section, stressing the importance of
    - (a) covering each target population with a range of prevention services,
    - (b) providing all services in the language(s) and at the literacy level(s) appropriate to the target population,
    - (c) offering prevention services at flexible hours that are appropriate to the target population, and
    - (d) performing interventions that (1) model the desired health behaviors in a real-life context (e.g., using realistic images as well as words) and (2) demonstrate how an adoption of those health behaviors will lower HIV risk.

- The general recommendation on confidentiality will be revised, to emphasize that different levels of confidentiality may be appropriate for different types of interventions.
- The general recommendation on evaluation will be re-written, to communicate the importance of evaluation to providers and to the planning process.
- New effectiveness data will be added to the section on community-level interventions.
- The write-up of media interventions will distinguish between the cost-effectiveness of small and large media forms.

DISCUSSION
Cynthia asked what the Subcommittee meant by "modeling" health behaviors, and whether that suggested that the people performing the intervention had to exhibit exemplary behaviors in their personal lives. Tracey clarified that the Subcommittee had decided to include this recommendation based on literature indicating that prevention efforts are most effective when safer behaviors are modeled through interactive interventions or visual representations. Just talking about risk reduction has not proven to be as effective. The Subcommittee did not mean to imply that providers must be perfect models of safer behavior in order to educate effectively. Cynthia suggested that a re-wording of this recommendation might help, then; "skills-building" and "efficacy" are more precise terms in this context than "modeling."

Kerrington proposed that the Council move to a vote on the chapters, which he explained would first appear as supplementary chapters to the HIV Prevention Plan for Year I. Yvonne asked how members could get the total Plan. Lyn replied that the document would be xeroxed no later than the first of February, and would then be distributed to all.

The Vote:
Approved: **15**
Opposed: **0**
Abstained: **1**

Kerrington followed the vote by praising the writing done by Harder + Co. staff on the chapters.

7. BREAK

8. CLOSURE
Completed. Valerie began, saying she was glad to have this opportunity to speak this year. Referring to the Year I Evaluation Report, she said that the first year process was characterized in part by confusion, mistrust, and frustration; but that it produced a Plan rated number one in the country. By this year, she said, the Council has developed a higher level of trust. Members have been working diligently all year on two subcommittees, and their work has been characterized by passion and dedication.

Valerie mentioned some of the losses suffered by the HIV prevention community in the last year: Noel Day, John Watters, Jeff Amory, and Matthew Boman. She called these men casualties of the AIDS effort, though their deaths were not directly related to AIDS. Valerie stressed the importance of what the Council has done for prevention education, and said that its members share the opportunity to lessen the number of new infections in San Francisco. In closing, she stated the need for this work and level of commitment to continue in the fight against HIV.

Kerrington expressed his sense that the way in which John Watters died (apparently through a drug overdose) is important to remember. It is even more important, he said, to remember what John Watters did for IDUs in San Francisco. As Kerrington put it, the most disenfranchised population of all those affected by the epidemic has benefited enormously from the work of John Watters. To be human is to be vulnerable, he said. He understood the news of John's death partly as a reminder to providers to pay attention to what is going on with their colleagues, their clients, and themselves. Kerrington explained that he had started his work with the CDC arguing for what they weren't doing and weren't including. Serving on the HPPC, members have had to come up with an inclusive working process and Plan that was ready on time. He said he felt these objectives have been achieved, and that the process has been characterized by respect and mutual learning. Kerrington thanked the community members of each community that came to participate in the Council meetings. In addition, he said he had learned a great deal from the other Co-chairs, and had felt encouraged at seeing such support from people in power (at the AIDS Office). In closing, he underscored Valerie's point that the work of the San Francisco HPPC has become a national success and example; he hears praise for it whenever he travels.

Cynthia described herself as having been more of a behind-the-scenes Co-chair in recent months (since Ana Claire was appointed). She said there is a lot about the Council that she will miss and that, in serving as Co-chair, she has established relationships on various levels with all kinds of people. She will also miss being able to say she is an active part of the Council, since -- like Kerrington -- she has had the experience of leaving San Francisco and hearing things about the Council that make her proud. She thanked everyone for their willingness to go through very hard times with the HPPC. In closing, she appealed to continuing members to stay on and keep bringing in their energy to this ongoing work of importance.

Ana Claire began by saying she will still be here for the new Council. She thanked all members leaving for the respect she felt from them and for all that they have accomplished. She expressed her gladness at being able to be with the Council to watch as implementation of its work begins.

At this point, Kerrington introduced Mitch Katz, who had just arrived. Mitch said it had been wonderful to review the recent grant application submitted to the CDC, and that he wished he could come to more HPPC meetings. He expressed his admiration for the work that has been done. In reading the minutes, he said, he has been able to appreciate the conceptual leaps made by the Council members. He noted the tremendous process of renewal that the Council undergoes each year.

Norm Nickens joined in expressing appreciation for the Council's work over the past year. He also notified departing members of the opportunity to work with the Health Services Planning Council, which is recruiting members currently and hopes to make connections with the HPPC. Notices will be going out to the departing members, telling them how to become involved.

9. AWARDS

Completed. Valerie and Ana Claire Meyer handed out tokens of esteem to the outgoing members. Kerrington then mentioned the AIDS Office staff members who have been instrumental in the work of the HPPC, and Valerie gave awards to Tracey Packer and Brian Dobrow. Valerie also gave plaques to Kerrington and Cynthia, for their passionate and dedicated performances in Year I and Year II. Finally, certificates of appreciation were distributed to both continuing and outgoing members.

Tamara Ching spoke up to add Sheri Webb to the list of people who have passed on in the prevention community. Sheri was a transgender counselor for the Tenderloin AIDS Resource Center; Tamara described her as "the utmost and foremost person in the African-American transgender community."

10. NEXT STEPS

Completed.

New Member Orientation Plans

Valerie announced that the Membership Selection Committee had met the day before. Notifications will go out to new members after the selections are approved by Mitch Katz, Director of the AIDS Office, and Sandra Hernandez, the Director of Public Health. The February 8 meeting will be focused on orientation and training for new and continuing members.

Committee Overview

Valerie passed around a description of the new committees (enclosed), along with a sign-up sheet for those who know which they want to join. Most committees will have continuing members, and some will include outgoing Council members. Community participation is also encouraged on most of the committees. Valerie noted that the descriptions and parameters of the committees are tentative now, and may change with members' input. The possibilities of having longer, less frequent committee meetings and of having joined committees are under consideration. The Evaluation and T.A. Committee has already met; this committee evolved out of the task force begun last year.

Kerrington suggested that members read the handout and give some thought to what they would like to be doing next year. He added that the committees should strive to keep some sense of continuity this time. Valerie asked members to let her know of their interest in committees by February 8. She also proposed having a meeting on February 15, to talk more about timelines.

Tamara advised new members that they should attend every meeting, or -- if they cannot --should leave a space open for someone else to fill.

Fernando asked whether Council members' roles and responsibilities were up for discussion on the 8th or the 15th. Valerie responded that this topic is on the agenda for the 15th.

Kiki said that, in leaving the Council, she feels concern about the future representation of the transgender community, and particularly of the FTM transgender community. She hopes that someone from the community has been selected, and urges the Council to open two slots for transgendered persons.

Joshua asked about the process for selection of Council Co-chairs. Valerie replied that, in the past, people were asked if they would like to be considered for the position, and then a silent vote was taken. Kerrington added that, according to the by-laws, the person to replace him should be a new member. Of the two community Co-chairs, at least one is supposed to have the benefit of experience with the Council in the previous year. Cynthia explained that it had seemed damaging to community representation to have both community Co-chairs come in new to the position at the same time. This factor for representation was recognized in Year I, and the by-laws were amended to create the lag period between community Co-chairs. Kerrington mentioned that Co-chairs have to attend the weekly Co-chair meetings and the annual CDC Co-chair meetings, as well as to represent the diversity of the Council. Valerie said that the Co-chair selection should take place

soon, and could happen at the February 15 meeting. ***Update:*** *Due to the needs for orientation and training of new Council members, it has been suggested that this action be delayed until at least March.*

Yvonne asked if the potential role of outgoing members could be discussed at the meeting on February 8. Valerie responded that the Council would like to solicit the perspective of outgoing, as well as continuing, members. She recommended that members call her with questions about the new committees and come prepared to make a choice by February 8 or, at the latest, by February 15.

11. EVALUATION

12 members filled out evaluation forms. 2 others did not answer the evaluation questions, but commented that the forms themselves were not useful for evaluating the meetings.

1.) On a scale of one to ten, the achievement of the objective: "To meet other HPPC members, learn more about and better appreciate their areas of expertise and contributions to planning," was rated at an average of **5.83**.

2.) On a scale of one to ten, the achievement of the objective: "To hear about, understand and adopt the report on Strategies and Interventions," was rated at an average of **8.16**.

3.) On a scale of one to ten, the achievement of the objective: "To hear about, understand and adopt the report on Priority Setting," was rated at an average of **8.16**.

4.) On a scale of one to ten, the achievement of the objective: "To hear and understand public comments," was rated at an average of **8.75**.

5.) On a scale of one to ten, the achievement of the objective: "To hear about and understand the new HPPC Committee Structure," was rated at an average of **8**.

The following comment was also submitted with a completed evaluation form:

> *I really hope we can work on our public comment structure. I hope we can still talk about having a greeting person for public comments.*

Next HPPC Meetings: Thursday, February 8 and Thursday, Feb 15 -- at the First Unitarian Universalist Church, 1187 Franklin St.

HIV PREVENTION PLANNING COUNCIL
PROPOSED COMMITTEES
FOR 1996

The following is a brief description of the Committees of the HPPC for 1996. This document has been prepared by the HPPC Co-Chairs.

Epidemiology, Future Directions (Needs Assessment) and Research Committee: to be composed of HPPC members, both continuing and outgoing, community members, AIDS Office Staff and consultants. To accomplish its task, it is proposed that this committee synthesize the results of the Priority Setting Chapter and the Strategies and Interventions Chapter, and data gathered in Year 1 to create a picture of HIV Prevention in San Francisco for 1996 and 1997. In addition, the committee will identify research priorities and contribute to the revision of the Epidemiology profile. The work of the committee will serve as a foundation for this chapter in the revised HIV Prevention Plan for San Francisco.

Resource Allocation and Resource Inventory Committee: to be composed of HPPC members, both continuing and outgoing, and the Director of the AIDS Office or his designee. To accomplish its tasks, this committee will 1) determine the broad, general guidelines for the language of the prevention based RFPs, 2) outline the overall parameters within which the AO will make funding decisions, 3) serve as representatives in the review of funding proposals along with other HPPC members--provided there is no conflict of interest, 4) assess the resource allocation process and advise the HPPC and AO regarding improvements in it, 5) revise, as needed, the resource inventory structure and methods for gaining information on prevention programs city/county wide, and 6) update the resource inventory based on current data. The work of the committee will serve as a foundation for this chapter in the revised HIV Prevention Plan for San Francisco.

Technical Assistance and Evaluation Committee: to be composed of HPPC members, both continuing and outgoing, community members, AO staff and consultants. This committee will work closely with the consultants employed through the Organization Development and Capacity Building and Technical Support contracts of the AIDS Office in 1) the development of a strategic plan for the evaluation of DPH and CBO prevention programs, 2) standardizing units of service for AIDS Office contracts, 3) standardizing behavioral and demographic characteristics which prevention providers will collect, 4) working with the Epi/Future Directions/Research Committee, 5) consulting on technical assistance planned by AO contractors, 6) assisting in training of providers and others on the HIV Prevention Plan and its recommendations. The work of the committee will serve as a foundation for this chapter in the revised HIV Prevention Plan for San Francisco.

Goals and Objectives Committee: to be composed of HPPC members, both continuing and outgoing, community members, AIDS Office staff and consultants. To accomplish its tasks, this committee will 1) review progress on the 1994 goals and objectives, 2) establish broad goals for HIV Prevention in San Francisco using data gleaned from the Epi/Future Directions and Research Committee, 3) specify goals for the HIV Prevention Planning Council , and 4) design broad objectives for prevention providers. The work of the committee will serve as a foundation for this chapter in the revised HIV Prevention Plan for San Francisco.

Linkages Committee: to be composed of HPPC members, both continuing and outgoing, community members, AIDS Office Staff and consultants. To accomplish its tasks the committee will 1) define guidelines for a system of referral between and among prevention providers, 2) define systems linkages with attention to inter-system, intra-system and internal system linkages of the prevention provider community, including funders. The work of the committee will serve as a foundation for this chapter in the revised HIV Prevention Plan for San Francisco.

Membership Committee: to be composed of HPPC members both continuing and outgoing, community members (specifically, but not solely solicited from the HIV Health Services Planning Council, the People of Color Advisory Committee and any Departmental Youth Advisory Committee, and AIDS Office Staff. To accomplish its tasks, this committee will 1) outline specific roles and responsibilities of HPPC members, Committee and co-chairs, 2) roles for and methods of gaining input from community members, 3) assist in the orientation and training of new members, and 4) assist in the recruitment and retention of HPPC members. The Committee also will develop procedures for guiding member and community involvement/participation in meetings.

Steering Committee: to be composed of the Chairs of each of the 1996 committees described above, the three HPPC co-chairs, AIDS Office staff and consultants. This committee will meet at least monthly to apprise one another of the activities and progress of each committee. In addition, this committee will review and revise, as needed, the bylaws and operating procedures of the HPPC.

Council Members' Role and Responsibilities

The HPPC is scheduled to meet as a full council once per month for two hours, throughout 1996. As in past years, HPPC members will be required to participate in committee activities as part of their responsibility to HIV prevention planning. The current idea is to hold longer, less frequent Committee meetings.

Because consistency in deliberations are critical to the success of these committees, members must be able to abide by the operating principles described below and with additional principles established by each committee once they have been constituted.

- Committee members are expected to attend all meetings
- Dates, times and places of meetings will be scheduled at times agreeable to all members (to the extent possible)
- Members are required to actively participate in all discussions
- Periodically review materials/minutes between meetings
- Question proceedings for clarity
- Support the Committee's actions to the HPPC and the community

Absences from committee meetings are considered absences as per the HPPC bylaws and will influence future participation in the HPPC.

Please indicate your interest in joining one (or more) of these committees on the attached sign up sheet.

In the event more than the optimal number of members sign up for any one committee, the HPPC co-chairs will appoint members to committees based on parity, inclusion and representation.

January 11, 1996/AIDS Office
o:wp/hppc/bylaws/comm1996

-SF

HIV PREVENTION PLANNING COUNCIL MEETING

February 8, 1996
3:00 PM to 6:00 PM (Please note the time change!)
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ana Claire Meyer
Valerie Kegebein

Please read: Minutes of January 11, 1996
Please bring: Bio Sketch

AGENDA

1.	Welcome	Valerie Kegebein	3:00-3:05 PM
2.	Introductions & Group Expectations	Tracey Packer	3:05-3:30 PM
3.	AIDS Office Overview	Valerie Kegebein	3:30-3:40 PM
4.	Orientation to HPPC	HPPC Members/Co-Chairs	3:40-3:55 PM
5.	Break		3:55-4:05 PM
6.	Orientation Continued	HPPC Members/Co-Chairs	4:05-5:45 PM
7.	Public Comment	Ana Claire Meyer	5:45-5:55 PM
8.	Evaluation	Ana Claire Meyer	5:55-6:00 PM

Up-Coming Meeting(s):

Evaluation & Technical Assistance Committee - February 22, 1996, 2:00 - 6:00 PM, 1360 Mission Street, 4th Floor

All other committee meetings (except Evaluation & Technical Assistance) - February 15, 1996, 3:00 - 6:00 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary)

HPPC - March 14, 1996, 4:00 - 6:00 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary)

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SF Dept. of Public Health

HIV PREVENTION PLANNING COUNCIL
MINUTES
February 8, 1996

DOCUMENTS DEPT.

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Members Present:
Barbara Adler
Ronnie Ashley
Isabel Auerbach
Hector Carrillo
Michael DeMayo
Christine Edwards
Patrick Forte
Roberto Garcia
Ellen Goldstein
Fernando Gomez-Benitez
Natalie Gutierrez
John Hamilton
Liz Highleyman
Valerie Kegebein
Sacul L'Adnbre
Marvin Lee
Ramon Martinez
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Chandra Pugh
Bethsaida Ruiz
Terry Ryan
Jay Seward
Zwazzi Sowo
Joshua Volle
Hank Wilson
Bobby Wiseman
Edward Zold

Members Absent:
Rafael Diaz
Percy Grant
Chinyere Madawaki
Dominic Perez
Joshua Tager

Guests:
Christina Goette
Rama Barnwell

AIDS Office Staff:
Kristen Clements
Brian Dobrow
Delia Garcia
Tracey Packer
Mike Pendo
Billy Pick

Harder+Co./Polaris, Inc.:
Mary Irvine (Polaris, Inc.)
Lyn Palco (Harder + Co.)

I. WELCOME

Valerie welcomed all the new members, and Brian noted that their appointments had been approved by the director of Public Health. He mentioned that the binders distributed to new members include a great deal of material, which may take people a few weeks to review fully. Valerie began the introductions, explaining that she is the HPPC DPH co-chair and the head of the Prevention Planning Policy & Health Education Unit of the AIDS Office. Valerie also introduced Brian Dobrow and Tracey Packer, who are planning coordinators in her unit; Ana Claire Meyer, who serves as a community co-chair; and Jonathan Brown and Joshua Volle, who are founding members with a continuing presence on the Council.

Valerie listed the following topics for discussion at this meeting:

- Responsibility and role of the AIDS Office
- Community planning principles

- Year I and Year II process and outcome
- Plans for Year III
- HPPC structure and meeting process, and the roles and responsibilities of members

She added that questions would be taken throughout the meeting.

II. INTRODUCTIONS AND GROUP EXPECTATIONS

Jonathan Brown asked that everyone present give his/her name and relationship to HIV prevention or agency affiliation(s). The new membership list will include agency affiliations whenever possible, and the more qualitative information on new members will soon be shared (in the form of biographical sketches) with the Council as a whole.

Following the introductions, Tracey and Jonathan directed an exercise on what the members expected to learn at this orientation. Through members' suggestions, the following list was created:

- Details of procedures for meetings (Robert's Rules of Order, voting, speaking, etc.)
- Membership of different committees and strategies for recruitment of community input
- Goals and objectives for this year
- Procedure for joining committees (voluntary or assigned?)
- Relationship between people's agency affiliations and their roles on the committees
- Relationship between community planning groups and the AIDS Office
- Details of time commitments involved with membership
- Attendance policies around illness and travel for work
- Role of the HPPC in the larger picture of prevention services in San Francisco

Tracey explained that the orientation would attempt to cover these topics, but that an in-depth committee membership discussion would have to be postponed, since most of the committees are in the earliest stage of forming membership.

III. AIDS OFFICE OVERVIEW

Valerie briefly addressed the relationship between the AIDS Office and the planning groups. The AIDS Office is responsible to the Health Commission, the Board of Supervisors, and the Mayor. The HPPC is a collaborative community effort (it is not driven by the AIDS Office). Last year, both the Board of Supervisors and the Health Commission accepted the HPPC Plan as the Prevention Plan for San Francisco.

The AIDS Office is part of the SFDPH and the Bureau of Epidemiology and Disease Control. It is organized in three branches: Research, Health & Prevention Services, and Seroepidemiology & Surveillance. In turn, the Health Services and Prevention Branch is broken down into three units: Epidemiology & Evaluation, HIV Prevention Planning Policy & Health Education, and Program Development. Brian noted that the orientation binder includes diagrams which explain the relationship of the various AIDS Office entities to one another.

Jimmy Naritomi asked about the connections being made between prevention planning and health services. Valerie responded by saying that this is a timely question, and that the co-chairs of each planning council expect to meet on a quarterly basis. The AIDS Office views the work of the HPPC as distinct from health services planning.

Valerie clarified that the HIV Prevention Planning Policy & Health Education Unit is responsible for the "cooperative agreement" funding to the HPPC. The AIDS Office manages 30 different prevention contracts, some of which have a health services component. The HPPC members' work will contribute to the structure of such contracts.

IV. ORIENTATION TO THE HPPC

History of Community Planning

Valerie explained that, in 1993, the CDC issued a mandate for a community planning process for any city or state which had a cooperative agreement with the CDC. In the first year, the primary goal of the HPPC was to create the San Francisco Plan within the six-month timeline. San Francisco was one of 65 CDC grantees who had to complete this task. The group worked in committees to produce the Plan. This first year developed:

- An epidemiological profile for SF
- Goals for the HPPC process
- The beginning of the priority-setting process
- The beginning of the process for recommending and outlining prevention strategies and interventions
- Ten overarching themes for prevention
- An identification of TA needs
- An evaluation of the planning process, performed by Dr. Kathleen Roe and her team

The chapters of the Plan set the groundwork for directions the Council took in 1995. However, the Year I Council did not finish defining strategies and interventions or setting criteria for priority target populations. The Plan identifies and responds to the following changes in provision of prevention services:

- As a result of shrinking federal funds, providers are required to give evidence of behavioral intent produced by prevention services.
- Prevention resources will no longer be targeted according to age, ethnicity, sexual orientation, or gender -- but according to the actual risk behaviors in which a population participates. Although providers will continue to serve particular demographic or identity groups, they will have to focus on changing behavior.

The HPPC followed guidance provided by the CDC for Year I, and successfully met its goals and objectives for the 1994 process.

Brian suggested that members read the summary document (in binder) on the Plan, before reading all of the Plan itself. He also recommended a reading of the Guide to the S.F. HIV Prevention Plan, which goes a little further in delineating the purpose of the Plan and the AIDS Office and HPPC expectations. Brian pointed out that the Plan is still being revised and will be re-printed later this year. It will then have more current goals and objectives, as well as more specific recommendations. Providers and the HPPC should be able to use it as a living document. Valerie strongly advised members to examine the "Needs Assessment", "Goals and Objectives", and "System Linkages and Coordination" chapters, which will be revised this year.

V. BREAK

VI. ORIENTATION CONTINUED

After the break, last introductions were made by members and guests arriving late.

Priority-Setting

Ana Claire explained that the 1995 Council had formed two subcommittees -- Priority-Setting and Strategies and Interventions -- to refine the 1994 work begun on these tasks. Joshua Volle offered a summary of the process and product of the Priority-Setting Subcommittee. The prioritization of populations for targeted prevention takes place in four phases. The first phase (summarized in the Phase I Matrix) multiplies the frequency of particular risk activities practiced in a behavioral group by the relative risk of each act (where vaginal receptive intercourse is set at a "3"), to create a basic score for each of twelve behavioral populations. The second phase adjusts the score for estimated population size and HIV prevalence. The final score produced determines the ranking of the twelve behavioral groups, starting with MSM-IDU as the highest priority group for prevention. Qualitative information enters the prioritization process in the third and fourth phases, which account for co-factors affecting the behavioral population and provider-specific information on a chosen target group.

Joshua said that the key point to remember about the priority-setting process is that the committee was following through on the Council's paradigm shift to a behavioral (rather than community) model for targeting prevention. He described the process as lengthy, arduous, debated, and complicated. This committee required and received a great deal of community input as well, to find a method for including transgender populations in the behavioral categories.

Valerie added that the committee process had been based on the Year I decision that prioritization should represent the efficiency of the transmission route. The Matrix accounts for the frequency of only the unprotected behavior (e.g., giving fellatio without a condom or sharing needles without sterilizing them). The other assumption behind the Matrix (and behind the relative risk estimates, specifically) is that there is one HIV-positive partner present for each risk behavior. In other words, the relative risk estimate depends solely on the efficiency of a transmission route, and not on HIV prevalence or any extenuating circumstances. The question for the committee and the researchers it consulted was, "As compared with an episode of unprotected receptive vaginal intercourse (where the insertive partner is HIV-positive), what is the likelihood of transmission in a given episode of, for example, unprotected anal insertive intercourse (where the receptive partner is HIV-positive)?"

Ana Claire explained the "alphabet soup" used to describe the components of each behavioral group. For example, #7 FSM&F-IDU breaks down as F; FTM (pre-op); MTF (post-op) - SM&F-IDU. The full description of this category would be: "females, transgender female-to-male (pre-operative) persons, and transgender male-to-female (post-operative) persons who have sex with males and females and inject drugs." With consultation from members of the Bay Area transgender community, the committee decided to group people according to the biological risks they face for HIV. These groupings left a total of twelve behavioral categories, each of which includes members of the transgender population.

Michael DeMayo asked whether the relative risk was calculated by group or by behavior, and Joshua responded that it was calculated for each behavior. He added that the committee had gathered information on the shifts in biological risk for transgendered persons participating in certain risk activities.

Lyn Paleo explained that researchers had offered their estimates of the per-act relative risk of behaviors. Receptive anal intercourse, for example, was assumed to be equally risky for whomever

engages in that act. The basic Matrix does not attempt to account for more subtle biological differences between people who participate in the same activity.

Joshua reviewed the list of co-factor categories (six in all), each of which includes some key example(s) described in the "Priority-Setting" chapter. The co-factors were identified as those conditions or factors which increase a person's risk for HIV, regardless of behavior. The chapter outlines the ways in which each co-factor (1) increases the motivation for risk behavior, (2) increases the susceptibility to HIV infection with a given behavior, and/or (3) decreases ability to receive and act upon prevention information. For each co-factor, the committee attempted to answer questions about the strength of the connection between that co-factor and HIV risk, the specific ways in which the co-factor increases risk, and the population groups characterized by the co-factor. Using this information, the representative of an individual organization/agency may point to certain co-factors as relevant to her/his target population, and argue for a higher priority for that group. Providers may also adjust the basic Matrix score for a target population, if they are able to offer different frequency, prevalence, or relative risk data.

Joshua closed by remarking on the fluidity of the priority-setting process. The committee strove to create a comprehensive and adaptable product, with lasting relevance to providers.

Strategies & Interventions

Ana Claire offered a summary of the process and product of the 1995 Strategies and Interventions Committee. Speaking first for both committees, she noted that members had experienced a persistent tension between the need to give solid guidance in the chapters and the need to allow for sufficient flexibility and provider input. She compared her committee's decision on prioritization of strategies and interventions with the Priority-Setting Committee's decision to add a Phase IV to the priority-setting process. Both decisions were made with the intention of formally including provider-specific information, input, and directions in the larger application process.

For the Strategies and Interventions Committee, the objectives were to create a common language around strategies and interventions and to create some criteria for their use with particular target populations. The committee members had to respond to the demand for a structure for comparison of different strategies and interventions -- in terms of their quality, appropriateness and effectiveness. The Strategies and Interventions Chapter can be divided into three basic sections:

1. General recommendations (articulating broader expectations and a philosophy of prevention)
2. Behavioral theory (explaining the relation of behavioral theory to program planning and summarizing the usefulness of different models for approaching behavior change)
3. Guidelines for each strategy and intervention (offering more specific direction)
    - definition/description
    - standards of service provision -- requirements and recommendations
    - expected outcomes
    - effectiveness data -- outcome effectiveness and cost effectiveness when available
    - suggested uses -- the advantages and considerations for use with populations defined by particular life conditions

Jimmy Naritomi asked if all the work of the committees was finished. Valerie replied that it was not finished in 1994, but was completed in the form of the two chapters released at the end of 1995.

Unmet Needs

At the end of 1994, the CDC earmarked additional funding for supplementary studies or programs under the cooperative agreement. The populations for which funding was set aside include young MSMs (particularly those of color and those engaged in survival sex), female partners of male injection drug users (particularly young women of color and women of color of all ages who fit this category), and injection cocaine and amphetamine users. The HPPC also identified research priorities for groups about which little is known, such as WS/MSM (females who have sex with males who have sex with males), and began examining linkages between counseling/testing and prevention services (e.g., how and when referrals are provided and what impedes clients from following up on those referrals). This year, funding has been earmarked for research on transgender populations.

The Evaluation & TA Committee -- Work Under Way

Ana Claire informed members of the role of the HPPC Evaluation & TA Committee in capacity-building. With the shift in prevention planning to a behavioral focus, there has also been a shift in the type of evaluation needed. Providers will be expected to demonstrate behavioral outcomes for their interventions, rather than simply relying on process outcomes. The 1996 Evaluation & TA Committee is standardizing the definitions for prevention service categories and units of service, and is creating common variables for behavioral outcomes and sociodemographic characteristics of clients.

Support Contracts

Valerie explained that there are two support contracts for the community planning effort. Harder + Co. provides technical support such as literature searches, background information on issues arising for the committee, writing, and assistance in keeping the committee on track and on schedule. Polaris Research and Development, Inc. has been working with Harder + Co. to provide some of the technical support, but has largely been responsible for logistical support to the Council and its committees. The minutes, mailings, meeting calendars, and refreshments make up the bulk of the logistical support. The Support Center, Polaris, Harder + Co., and Communication Sciences have been contracted to do technical assistance in 1996 on the organizational development and capacity-building TA task, preparing prevention providers to meet the new expectations for state and CDC funding. The four support contractors will submit regular progress reports on their activities.

Organizational Development and Capacity-building TA

Ana Claire mentioned that the CDC supplementary funds for organizational development and capacity-building TA will be used to assess and assist both community-based prevention organizations and DPH prevention programs. This contract is beginning with a needs assessment (by mail and through site visits) in March. In July, the technical assistance will be provided to several agencies that need it and match certain other criteria (as yet to be defined). The needs assessment is looking at program development (use of the Plan), implementation issues (staffing and organizational structure), and data collection tools. Needs assessment results will be brought back to the community and the Council, and the decision will be made, in partnership with the AIDS Office and the HPPC, as to how to distribute the TA.

Hank asked about a timeline for the TA. Valerie responded that the AIDS Office and the STD/HIV Prevention Training Center will begin to provide TA soon; the on-site TA will probably start in the fall. Hank also wanted to know if an organization's desire for TA could be one of the

criteria for its provision. Valerie replied that it could be considered criteria, but that most organizations seem to view the opportunity to receive TA as a benefit.

RFPs and Funding

Valerie explained that the AIDS Office will send out one RFP in June and one in the fall. The proposals will be expected within six weeks of the RFP release. The contracts will be developed in August through October. The Plan and the TA will delineate the structures, procedures, recommendations, and guidelines for everything that is going to change in prevention provision. As Valerie put it, a whole new playing field is taking shape, and it will allow for new types of collaborations. The work of the Council has been building up to a full implementation of the Plan.

Ellen asked about the Council's role in developing the RFPs, and Valerie said that the Council will develop the guidelines for the structure of the RFPs. Members will also be considered for the review panel. However, the AIDS Office ultimately determines who will get the contracts. As Joshua put it, HPPC members cannot actually decide who gets funding or how much they get; they can only drive these decisions through their recommendations. This year, the AIDS Office is receiving a block grant from the state. All of the state prevention funding (except for statewide initiatives) will be channeled through the AIDS Office for fiscal year 96/97. Previously, the state directly funded a number of agencies that did not go through the AIDS Office. The State Office of AIDS will continue to distinguish between statewide initiatives and local initiatives. The difference is simply that the AIDS Office has been asked to distribute all of the state prevention funding to San Francisco County, and to do it according to the priorities of the AIDS Office and the HPPC. Jimmy asked about what would happen with federal funds, and Valerie replied that it is still unclear. The AIDS Office expects to keep receiving the CDC funding, but cannot be sure. Anyone will be able to apply for CDC funding, whether or not they have received this funding in the past. The funds behind the RFPs include CDC funds, state funds, and general funds.

HPPC structure and procedures

Brian spoke on the topic of meeting structure and procedures. He described the Council as following a modified version of Robert's Rules of Order for parliamentary procedure. People cannot just speak whenever they are ready. As often as possible, the Council operates on a consensus basis; it reverts to a vote when necessary. A motion must be made and followed by a second, before a vote can be taken. The Council tries to provide for community participation, in the form of public comment or testimony. Recently, the public comment section was moved to the beginning of the meeting, so that comments could be made on each agenda item and before the vote.

Brian noted that some of the meeting agendas will be extremely full this year and may seem overwhelming at times. The Council may need to meet up to twice a month, on the second and/or fourth Thursdays. Ordinarily, it will meet from four to six in the evening, but some meetings will extend beyond those hours. Most of the actual discussion should take place in committees, though. In all, there are six new task-oriented committees and one steering committee. The decisionmaking process of the Council (Robert's Rules, etc.) is generally followed by the committees as well.

There will be three co-chairs (though there are only two right now). Until another community co-chair is found to serve with Ana Claire and Valerie, Kerrington may function as the interim co-chair. Nominations for the next community co-chair (who serves a two-year term) will be taken at the first meeting in March. Then the election should take place some time in April. Joshua reminded members that the third co-chair will be chosen from among their number.

The by-laws call for the retirement of one-half of the Council at the end of every year. The new membership is staggered (like the community co-chair positions) so that there will always be a mix of people who have experience on the Council and those who are newcomers. This time, 19-20 out of 30 positions became available at once. Ten continuing members were present at this meeting.

Minutes and other materials generally arrive in the mail about one week before the meeting at which they will be discussed. The agendas distributed before meetings indicate which materials members will need to bring with them. A few extra copies of the minutes or other important materials are generally brought to the Council meetings. If a member realizes that she or he has not received a mailing, that member should call Mary at Polaris: (415) 777-3229. This is also the contact to call for any changes or corrections to the address, fax, phone, and agency information on the membership list.

For more specific questions on operating procedures, Brian suggested that members refer to the summary document in the binder. Because the decisions of this body have considerable impact on the way prevention programs will be conducted in San Francisco, its actual procedures will be under constant and intense scrutiny. Brian added that the HPPC must be above reproach.

Hank mentioned that members may participate on more than one committee. Last year he participated on both committees, though he could vote on only one. Hank suggested that members can provide a valuable community perspective to different committees. Barbara asked if members would be receiving the minutes for all committees. Brian replied that they would instead receive the minutes of those committees which they attend or which particularly interest them. A separate set of mailing labels is being made for each committee. If members wish to receive any minutes for committees they do not plan to join, they should inform Mary, the logistical support person. Brian noted that communication between committees will also flow through the Steering Committee (the HPPC co-chairs receive all committee minutes).

Joshua pointed out that the decisions of the committees are not final; they must be brought back to the total Council, where they are often amended before approval. He encouraged community members to attend committee meetings, where in-depth discussion of planning issues can take place. Ana Claire added the note that community members will be able to serve as voting committee members this year -- as long as they get involved early and attend regularly.

Roles and Responsibilities

Tracey catalogued the responsibilities of each of the entities involved with the planning process:

Co-chairs (one DPH and two community co-chairs)

- planning and facilitating Council meetings
- attending Steering Committee meetings and planning agendas
- making policy decisions, with input from the Council members
- representing the HPPC collaboration
- serving as liaisons to the AIDS Office staff and to the CDC
- seeing the bigger picture and thinking beyond their areas of expertise

HPPC members

- attending meetings of the Council and chosen committees

- reading minutes and other documents prior to discussion and voting on them
- representing expertise due to agency affiliations and community involvement
- giving input on decisions being made
- seeing the bigger picture and thinking beyond their areas of expertise

Tracey added that members can and sometimes do set up meetings to facilitate communication between the HPPC and their constituencies. They may also bring in people for public comment.

AIDS Office staff (Brian Dobrow, Tracey Packer, Delia Garcia, Kristen Clements, and Billy Pick)

- attending Council meetings
- staffing committees (only applies to some staff members)

Consultants

- logistical support (minutes, food, calendars, mailings, etc.)
- technical support (outside information, literature searches, assistance with direction of tasks, etc.)
- needs assessment, TA (performed by the Support Center and Communication Sciences)
- HPPC process evaluation (performed by Dr. Kathleen Roe and her team of evaluators)

The other player in the HPPC process, Tracey said, is the public. They are the Council's larger constituency; the HPPC should be working for and with the public. Tracey expressed that the Council wants to make the public aware of topics on its agenda, so that members of the public can speak to the Council on those specific issues. The HPPC is still reviewing the best way to include the public and recruit community participation.

Jimmy asked who writes the proposals to the CDC from the HPPC. Tracey answered that Brian Dobrow takes primary responsibility for the writing, and that the proposals are also written according to directions the HPPC is taking.

Valerie introduced Christina Goette, one of the process evaluators. Christina explained that Dr. Roe's team intends to have a representative at all Council meetings. The team will provide ongoing feedback on the process they observe. Next week (Feb. 15), Dr. Roe will attend to discuss what the evaluators are putting together for the Year II report, and the prospective Year III evaluation. She expects to get comments from Council members on the work her team is doing.

Meeting Wrap-up and Final Announcements

Note: Valerie will need to collect the bios on all new members.

Valerie explained that this year's Council has the job of following through with implementation of the recommendations from the Plan. She announced that the AIDS Office would hold a press conference on Friday, February 16, from 9am to about noon, in the lower level New Conservatory Children's Theatre. Valerie and community Co-chairs Ana Claire Meyer (95/96), Kerrington Osborne (94/95), and Cynthia Gomez (94/95) will give brief presentations on the HPPC process thus far. There will also be a Q & A period at the end of the press conference, so that community members and AIDS Office staff may discuss the impact of the Plan on prevention providers.

The sign-up sheet for committees was then passed around to all members at the table. Valerie noted that the Council must begin planning the activities of those committees. Members were told that they may choose whichever committee they prefer, but that they may not get their first choice

(since each committee must meet the requirements for parity, inclusion, and diversity of expertise). Valerie reiterated that the Council is serious about wanting to get community participation on all the committees. The estimated time commitment for HPPC members, she said, is about four hours a month for Council meetings, in addition to committee hours. If a member is absent more than twice in a two-month period (from the Council or from a committee), that person will be contacted about his or her interest in remaining a member (of the Council or committee, respectively). In cases where the person is still contributing, keeping up, and trying to come to meetings, the HPPC tends not to ask for a resignation.

Kristen mentioned that the Evaluation & TA Committee began last year (as a Task Force), and is now meeting once a month for four hours at a time. Its goal is to assist CBOs with evaluation measures that carry out the intentions of the Plan. The Epidemiology & Research Committee will eventually work with this committee.

The co-chairs gave brief descriptions of the other committees forming (see the AIDS Office summary document for proposed committees -- everyone ought to have received this already).

In answer to a question about the wording of the agenda, Ana Claire told members that the February 15 meeting is being held largely as an opportunity for committees to meet and begin getting organized, since this is a new Council.

Valerie thanked everyone for coming, and observed that there is a great deal of expertise in this group. She said she was looking forward to working together.

Kristen announced that people still interested in joining the Evaluation & TA Committee should talk to her, and would be caught up on what has happened up to this point. She also said that people on her committee do not need to come to the meeting on February 15.

Regarding absences due to sickness or travel, Valerie told members to refer to the by-laws for now, but added that those by-laws will be revisited and may be revised this year.

VII. EVALUATION (26 of the 29 members turned in marked evaluation forms.)
1. On a scale of one to ten, the achievement of the objective: "To meet other HPPC members, learn more about and better appreciate their areas of expertise and contributions to planning," was rated at an average of **5.46** (with all of the 26 respondents answering).
2. On a scale of one to ten, the achievement of the objective: "To hear about and understand the AIDS Office structure and its relationship to the HPPC," was rated at an average of **8.35** (with all of the 26 respondents answering).
3. On a scale of one to ten, the achievement of the objective: "To hear about and understand the principles of HIV prevention community planning," was rated at an average of **7.42** (with 24 of the 26 respondents answering).
4. On a scale of one to ten, the achievement of the objective: "To hear and understand the structure, operating procedures, and member roles and responsibilities of the HPPC," was rated at an average of **8.31** (with all of the 26 respondents answering).
5. On a scale of one to ten, the achievement of the objective: "To understand what the HPPC 1996 tasks are and how they will be accomplished," was rated at an average of **6.63** (with 24 of the 26 respondents answering).

6. On a scale of one to ten, the objective: "To hear and understand comments from public participants," was rated at an average of **4.60** (with 15 of the 26 respondents answering).

Additional Comments

Seven evaluation forms included written comments in the space provided for this. Three members expressed a wish to receive important materials sooner, so as to be able to refer to them quickly in meetings. One continuing member was concerned that the committee meeting dates and times were still unclear, making it difficult to decide which to join. Another suggested that a different room set-up or seating arrangement would allow for more dialogue and group participation. A third continuing member wondered how members of the Council can support each other in the overwhelming process, and recommended the development of a team-building strategy. There were a few comments about the length of the meeting, but one new member added that the information given was necessary and useful. A continuing member commented in the margin next to the first objective that "brief blurbs (introducing Council members) aren't enough." The following comment was offered by a new member:

> *My tenure on this Council will be to represent the FTM community to the best of my ability. I will be advocating for a position for the MTF community as well, so that all components of this community are represented. This is a great day for the FTM community.*

Procedure for Upcoming Evaluations

In the future, the process evaluation team led by Dr. Kathleen Roe will analyze and summarize the meeting evaluation forms. The responses to the three open-ended questions on the form for this meeting will be described in an attachment (from the evaluators) to the minutes of February 15. Evaluations should be filled out, on both sides, by all members present at a given HPPC meeting. Those who offer written comments should always check the box indicating whether their comments can or can't be shared with the Council. Finally, the completed forms can be left with a member of the evaluation team.

Enclosed with these minutes:

(1) p. 78 of the "Priority-Setting" Chapter, missing from copies mailed
(2) a Women's Needs Center flyer, distributed to people at this meeting

Minutes Recorded by: Mary Irvine
Minutes Approved by: Valerie Kegebein

HIV PREVENTION PLANNING COUNCIL

February 15, 1996

The Agenda of this meeting is missing.

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HIV PREVENTION PLANNING COUNCIL
MINUTES
February 15, 1996

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Members Present:
Barbara Adler
Ronnie Ashley
Isabel Auerbach
Michael DeMayo
Christine Edwards
Patrick Forte
Roberto Garcia
Ellen Goldstein
Fernando Gomez-Benitez
Natalie Gutierrez
John Hamilton
Liz Highleyman
Valerie Kegebein
Sacul L'Adnbre
Marvin Lee
Chinyere Madawaki
Ramon Martinez
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Chandra Pugh
Bethsaida Ruiz
Zwazzi Sowo
Joshua Volle
Hank Wilson

Members Absent:
Hector Carrillo
Rafael Diaz
Dominic Perez
Terry Ryan
Jay Seward
Joshua Tager
Bobby Wiseman
Edward Zold

Guests:
Charlotte Kent, STD/HIV Prevention & Control
Kiki Whitlock, Asian AIDS Project (outgoing member)

Polaris, Inc./Harder + Co.:
Mary Irvine, Polaris
Lyn Paleo, Harder + Co.
Eden Tanovitz, Harder + Co.

Process Evaluation Team:
Cindy Berenstein
Christina Goette
Paul Lund
Kathleen Roe
Kevin Roe
Valerie Paz Soldan

AIDS Office Staff:
Kristen Clements
Brian Dobrow
Delia Garcia
Marshia Herring
Tracey Packer

I. WELCOME & INTRODUCTIONS

Members, guests, AIDS Office staff, and support team members introduced themselves. When the meeting began at 3pm, a quorum had not yet been achieved -- partly because many members were under the impression that the meeting time was 4-6pm.

II. ANNOUNCEMENTS

- Valerie reminded all present that the AIDS Office press conference on the activities of the San Francisco HIV Prevention Planning Council would start at 9am on Friday,

February 16, in the lower level of 25 Van Ness Ave. (the New Conservatory Children's Theatre). Dr. Sandra Hernandez would make the opening presentation, followed by AIDS Office staff and community co-chairs. Valerie explained that a Q & A session (between presenters and community members) was scheduled for 10am.

- Marshia Herring announced a meeting of the California HIV Prevention Working Group at the Park Oakland Hotel, March 14 and 15. The group will take public comments from 9am-10:30am on March 14, and from 1pm through the afternoon on March 15. She distinguished this group from the local planning group, in that the CPWG makes decisions about funding allocation. She added that there had been a real struggle last year to maintain funding levels for San Francisco and Los Angeles. As she put it, there is a need for a San Francisco presence at the CPWG meeting, especially in order to address the proportion of funding for prevention to gay male communities, in relation to the epidemiological profile for San Francisco.

- Marshia Herring also informed people at this meeting that the CPWG is currently trying to recruit HIV-positive individuals to serve as members. Anyone interested in responding may contact Sandy Sims of the State Office of AIDS, at (916) 323-4325. Resumes or applications for the available seats are due by April 15, 1996.

- Brian explained that the packets needed for this evening's discussion could all be found on the table at the entrance. Among these materials (enclosed as needed), members will notice a single sheet with information on the operating procedures of the HPPC (including a summary of Robert's Rules of Order). He suggested that everyone look over these notes on why and how the Council functions as it does.

III. PUBLIC COMMENT

No public comments were offered at this time.

IV. EVALUATION TEAM PRESENTATION

Dr. Kathleen Roe introduced herself as a professor in Community Health Education at San Jose State University. She explained that she had had her introduction to HIV/AIDS when she was working as the youngest staff member at a resource center for cancer and epidemiology, and was assigned to investigate the first wave of Kaposi's Sarcoma cases appearing in New York City. Speaking today as the leader of the process evaluation team for the HPPC, she said that she would present an outline of how the evaluation team would work on Year III and how members could become involved in this effort.

Goals of Evaluation

- help the Council to uphold the CDC grant requirements:
  1) parity (every member has an equal vote)
  2) inclusion (all communities have a chance to be heard)
  3) representation (the membership represents the current and projected epidemic)
- tell the story -- give an account of the experience from the members' perspectives
- bring out subtexts -- dramas, feelings, struggles, and issues faced by the members
- enhance the capacity of the Council -- help the planning group meet its objectives (the team will use evaluation on a monthly basis to do this)

Method of Evaluation

- frame the issues and set the scope for the evaluation (along with the HPPC)
- be present -- team members will observe the everyday work of the Council
- offer opportunities for members to give feedback (at meetings, on written forms, and in other communications)
- give back results of evaluation measures -- share information with the Council
- offer analysis of the data and comments received from members
- give perspective (on the process, from an informed outsider position)

Questions to Determine Validity of Evaluation Instruments and Interpretations

- resonant? (Are your comments represented? When hearing results, do you think, "that sounds about right," or "that makes sense"?)
- useful to the process?
- help to better understand self and others?

Dr. Roe had members read aloud the comments made on the evaluation forms from the meeting of February 8. She suggested that people hold on to the comments (enclosed for absent members) and look at them again when they need a boost or a reminder of why they are working with the HPPC. She also noted that the continuing members had given this new year a generous opening. She explained that the "three words" question is one of her favorite evaluation tools; it gives a sense of what has been going on inside people as they sit around the table together. By being as clear as possible in their evaluations, members can help Dr. Roe's team reach an accurate interpretation of their responses. Dr. Roe noted that, at the last meeting, 29 members had attended and 26 had turned in evaluation forms. Twenty-three had answered at least part of the open-ended questions section at the end. A handout (enclosed for absent members) distributed by the evaluators gives the breakdown and analysis of comments from last time. Members are encouraged to give their feedback on these analyses. At this meeting, the evaluation team used three separate instruments for collecting data: (1) the participant dialogue boxes, (2) the experience checklist, and (3) the regular yellow evaluation sheets with scales and questions.

V. BREAK

After the break, Ana Claire spoke briefly to say that members who have private comments to make to the co-chairs can also just send them a letter or give a call. In other words, the participant dialogue boxes are not the only opportunity for this type of private communication.

VI. HPPC COMMITTEES

Valerie mentioned that the sign-up sheets for committees had been circulated twice before. She introduced the proposed membership lists for new committees, saying that everyone got his or her first or second choice, and that the co-chairs strove for parity, inclusion, representation, and diversity of expertise on the committee level. (The proposed membership lists are enclosed, along with notes on the purpose and composition of each committee.) The individual committees were described briefly. Members were asked to try out their assigned committees at this meeting. Anyone who finds that his or her assignment will not work out should talk to Ana Claire and Valerie about a possible reassignment.

General Committee Structure

Each committee will have at least one AIDS Office staff member, co-chair, and consultant regularly attending meetings. Both logistical and technical support will be provided to all committees. The work of each committee (except for the Steering Committee and Membership Committee) will lay the foundation for a chapter in the revised Plan. Every committee will have a chair, who will attend the monthly (or so) meetings of the Steering Committee. The revised handout on the committees (enclosed) includes an outline of committee members' roles and responsibilities. *Note:* the by-laws are being reviewed by the Steering Committee, so some of the responsibilities and requirements may eventually change.

Committees will set their own meeting times. Any decision made in the committee setting is brought back to the Council, for adjustments and revisions and eventual approval. Everyone who consistently attends a committee will have a vote in its deliberations; however, only Council members may vote at a full Council meeting. The committees, like the Council, strive for a consensus on all decisions. Barring consensus, the committee will move to a vote and act on the majority. Members may be asked to bring some materials to help with the work of their committee. If necessary, they can ask the AIDS Office for help in gathering such materials. The technical support team can also help with finding appropriate literature or research data.

Immediate Committee Tasks

Brian explained that the committees would be convening briefly tonight to set their first meeting date and time. The dates would then be checked with the consultants, to make sure that no-one is expected in two places at one time. Sacul asked about the time commitment for committees, and Valerie explained that every Council member should be able to spend up to eight hours each month on HPPC activities (two to six hours in addition to the regular Council meeting time, which is about two hours). The meeting locations may be set by the committee members, and the AIDS Office can usually make a room available. Those committees feeling ready to do so were also encouraged to select or consider a chair at this meeting, and to review the purpose and activities of the committee. The times for the Steering Committee will depend partly on the other committee meeting times.

VII. COMMITTEE DISCUSSIONS (Break Outs)

The committees (with the exception of the Evaluation & TA Committee) gathered in different areas of the room.

VIII. COMMITTEE REPORTS

Membership Committee

New committee Chair John Hamilton spoke for this committee. In addition to working on recruitment and retention of HPPC members; gathering and examining community input to the HPPC; and defining the roles, responsibilities, and benefits of Council membership; the committee will review reports from the evaluation team for content relating to membership issues.

Next Meeting: Tuesday, March 19, from 3:30 to 5:30pm at the AIDS Office

Epidemiology & Research Committee

Sacul L'Adnbre, who announced that she is not going to chair, spoke for this committee. She explained that it is a fairly large group, and it will be reviewing and revising the existing Epidemiologic Profile. As it sets future research priorities, the committee will work alongside the Evaluation & TA Committee and the Goals and Objectives/Future Directions Committee.

Next Meeting: Wednesday, March 6, from 4 to 7pm at the AIDS Office (Lyn Paleo will bring a list of relevant terminology.)

Resource Allocation & Resource Inventory Committee

Jimmy Naritomi spoke for this committee. He said that the group had discussed its role (and the CDC role) in setting guidelines for the prevention RFPs, and had begun to talk about the timeline for meeting its objectives. He explained that the question of a chair had been postponed, because not enough members had been present.

Next Meeting: Tuesday, February 27, from 2 to 4:30pm at the AIDS Office

Linkages Committee

Ronnie Ashley (Chata) spoke for this committee, which had not been able to choose a chair because two of the members were absent. He said that the group present had spoken with Eden Tanovitz about how to accomplish its tasks without re-inventing the wheel. At the next meeting, existing service linkage systems and contracts will be presented to the committee.

Next Meeting: Wednesday, March 6, from 3:30 to 5:30pm at 1360 Mission St., 4th Floor

Goals & Objectives/Future Directions Committee

Ramon Martinez spoke for this committee. He mentioned that Ana Claire Meyer had already given the group a reading assignment for the next meeting (the two 1995 chapters and the "Goals and Objectives" chapter in the 1994 Plan). At that time, the committee will also discuss the matter of selecting its chair.

Next Meeting: Friday, March 1, from 9am to noon at the AIDS Office

Valerie pointed out that some committee members will have useful and/or necessary information for other committees, and she asked that they communicate that information through the committee chair, AIDS Office staff, consultants, or some other representative (if they cannot attend the committee themselves). Liz wondered if each committee could give regular reports to the HPPC, and Valerie affirmed that these reports will be scheduled for certain Council meetings. Valerie explained that part of the purpose behind scheduling the first committee meetings was to begin recruiting community participation at these meetings. Members are encouraged to start getting out the word about these dates, times, tasks, and objectives.

IX. LAST ANNOUNCEMENTS AND QUESTIONS

- Dr. Roe clarified that there are two separate evaluation efforts going on at once in the HPPC; the committee effort will examine and refine the tools of program evaluation, while her team will be conducting an ongoing evaluation of the actual HPPC process. Dr. Roe can be contacted by phone at (510) 944-0570, or by fax at (510) 943-2229. She is hoping to form an ad hoc advisory committee to give focused and in-depth feedback to the evaluation team. Ideally, this committee would be able to convene some time in the next month. Those who are interested in the advisory committee should call Valerie Kegebein at the AIDS Office (554-9023) or Kathleen Roe at the number above.

- Sacul asked why the meeting had been held from 3-6pm tonight, instead of 4-6pm. Valerie responded that the meeting time would usually be 4-6pm, as Sacul had thought, but that it had been extended for the orientation this week and last week. Generally, the AIDS Office will prepare HPPC members by faxing a meeting agenda, with the correct time and location of the meeting.

- Liz brought up a problem with faxes received from the AIDS Office. She explained that the shaded area doesn't read well through the fax, and that plain paper with boxes and/or very slight shading would work better. Valerie said the format could be changed to improve readability.

- Hank suggested that members consider pairing up with someone else on the Council, so that each person has a contact for catching up on meeting business when one or the other person is late or absent. He added that forming this kind of bond with another member can also help everyone get through the difficult aspects of serving on the Council.

- Brian Dobrow announced that he can offer interested members the opportunity to attend the National AIDS Update Conference (March 20-22, in the Bill Graham Auditorium -- formerly the Civic Auditorium) for free on any given day. As a result of his position as volunteer coordinator for the conference, Brian can assign volunteer "room monitors" to check people in at the workshops. Those who volunteer for a workshop can attend the conference all that day without paying for registration. If someone volunteers for a workshop on each day, then that person may go, for free, to the entire conference. At the end of February, Brian will try to put out a notice about this opportunity. In the meantime, he can be reached at the AIDS Office (554-9499).

- Valerie gave more detail about the Friday press conference at the SFDPH. She said that Dr. Hernandez would be giving a summary of the first two years of the HPPC; Valerie would speak about who is represented by the Council; Cynthia Gomez would discuss the prevention priorities established by the Council (such as the paradigm shift to a behavioral, rather than community, model); and Ana Claire Meyer would address the collaboration involved with this community planning effort.

- Valerie also informed members that the March 14 Council meeting will include a discussion about how to replace Kerrington Osborne with a new community co-chair. A summary of co-chair roles and responsibilities will be issued before this meeting.

X. ADJOURNMENT

Enclosed with these minutes:

(1) handouts from the Process Evaluation team (enclosed only for absent members)
(2) HPPC operating procedures document
(3) descriptions of proposed committees (and members' roles and responsibilities)
(4) initial membership lists and statements of purpose for each committee
(5) explanations of the composition and tasks of each committee
(6) calendar of HPPC-related meetings planned for the month of March

Next Meeting: Thursday, March 14, from 4-6pm -- at the First Unitarian Church, 1187 Franklin

Minutes Recorded by: Mary Irvine
Minutes Approved by: Valerie Kegebein

THE HIV PREVENTION PLANNING COUNCIL AND THE AIDS OFFICE OF THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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INVITE

HIV PREVENTION PROVIDERS
&
INTERESTED INDIVIDUALS

to a

PRESS CONFERENCE & COMMUNITY MEETING

Public Meeting

on the HIV Prevention Plan, its priorities and the change in direction for HIV prevention in San Francisco

FRIDAY, FEBRUARY 16, 1996
9:30 a.m. - 12:00 noon

at the
New Conservatory Children's Theatre
(lower level)
25 Van Ness Ave.

This is your opportunity to hear first-hand about the priority populations, guidelines for strategies and interventions, and the paradigm shift from targeting traditional populations by age, gender and race/ethnicity to targeting the specific behaviors that put individuals at risk for HIV infection. We invite you to attend.

HIV PREVENTION PLANNING COUNCIL MEETING

March 14, 1996
4:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer

Please read: Minutes of February 15, 1996

Please bring: Entire package

Agenda

1.	Welcome & Introductions	Valerie Kegebein	4:00-4:05 PM
2.	Minutes	Valerie Kegebein	4:05-4:10 PM
3.	Announcements	Valerie Kegebein	4:10-4:15 PM
4.	Public Comment		4:15-4:25 PM
5.	Membership Update	Valerie Kegebein	4:25-4:30 PM
6.	Update from HIV Prevention Community Planning Co-Chairs Meeting in Atlanta	Ana Claire Meyer	4:30-4:40 PM
7.	Community Co-Chairs Nomination Process	Ana Claire Meyer	4:40-4:50 PM
8.	Break		4:50-5:00 PM
9.	Committee Updates	Chairs/Consultants/AO Staff	5:00-5:50 PM
10.	Evaluation - Adjournment	Kathleen Roe	5:50-6:00 PM

NEXT MEETINGS: **REVISED 3/14/96**

For meetings at the AIDS Office, please always check in with the receptionist on the 5th floor.

HPPC - April 11, 1996, 4:00-6:00 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary)

Membership - March 19, 1996, 3:30-5:30 PM, AIDS Office, 25 Van Ness Avenue, 5th Floor.

Resource Allocation/Resource Inventory - March 19, 1996, 10:00 AM-12 Noon, AIDS Office, 25 Van Ness Ave, 5th Floor.

Epi & Research - March 26, 1996, 4:00-7:00 PM, AIDS Office, 25 Van Ness Avenue, 5th Floor.

Linkages - March 26, 1996, 2:00-5:00 PM, AIDS Office, 25 Van Ness Avenue, 5th Floor.

Evaluation & Technical Assistance - March 28, 1996, 2:00-6:00 PM, 1360 Mission Street, Suite 400.

Goals & Objectives - March 29, 1996, 9:00 AM-12 Noon, AIDS Office, 25 Van Ness Avenue, 5th Floor.

SF Public Health

HIV PREVENTION PLANNING COUNCIL
MINUTES
March 14, 1996

Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Isabel Auerbach
Hector Carrillo
Patrick Forte
Roberto Garcia
Ellen Goldstein
Natalie Gutierrez
John Hamilton
Liz Highleyman
Valerie Kegebein
Marvin Lee
Chinyere Madawaki
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Dominic Perez
Chandra Pugh
Bethsaida Ruiz
Jay Seward
Zwazzi Sowö
Joshua Tager
Joshua Volle
Hank Wilson

Members Absent:
Michael DeMayo
Rafael Diaz
Christine Edwards
Fernando Gomez-Benitez
Sacul L'Adnbre
Ramon Martinez
Terry Ryan
Bobby Wiseman
Edward Zold

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AIDS Office Staff:
Kristen Clements
Lyn Fischer-Ponce
Tracey Packer

Evaluation Team:
Rama Barnwell
Cindy Berenstein
Paul Lund
Kathleen Roe
Kevin Roe

Guests:
Kiki Whitlock, AAP and TG Community Task Force
Liz Rojas, SFDPH

1. WELCOME & INTRODUCTIONS
Valerie Kegebein convened the meeting, and those present briefly introduced themselves.

2. MINUTES OF 2/8/96 AND 2/15/96
The minutes were approved without exception.

3. ANNOUNCEMENTS
- Liz Highleyman presented a letter to providers from the Coalition on Bisexuality and HIV Education and Prevention (enclosed for members). The letter introduces an assessment that the Coalition is conducting of HIV/AIDS prevention and education services available to people who have sex with more than one gender and/or who are bisexually identified. Responses from Council members are encouraged, and may be sent to the address at the top of the letter (584 Castro St., Box #422 / San Francisco, CA 94114) or given to Liz Highleyman.
- Hank Wilson announced a community forum (sponsored by Q Action and Stop AIDS Project) on the use of speed in the queer community. The forum has since been held (on March 21st), but the flyer is enclosed for Council members.

- Valerie announced that two people will be selected nationally to participate in the CDC Price Fellowship, a group focusing on leadership in prevention planning. The criteria for eligibility for the fellowship include:
    - ° strong knowledge of and commitment to HIV prevention
    - ° two or more years of experience in a CBO
    - ° understanding of HIV prevention at a local and/or state level

  Members of the Council may nominate themselves or others for the fellowship.

4. PUBLIC COMMENT

- Kiki Whitlock, the transgender services coordinator for the Asian AIDS Project, addressed the Council about the transgender study that was to be performed this year by the AIDS Office. She said that she had had an opportunity to give public testimony to the California Planning Working Group and the State Office of AIDS, about the need for gathering research data on transgender populations. She wanted to extend the same opportunity (for data collection on transgendered persons) to the San Francisco HPPC. Kiki said that the San Francisco study would be important to getting the state-level research process in motion. Turning to the co-chairs, she asked what the timeline is now for this study.

  Valerie responded that she had received a letter from the State saying that the joint HPPC/AIDS Office application, which included a general description of the transgender study, had been approved -- but that the funding would not be available until July 1, 1996. She added that she will have more to say about the study, after there have been further negotiations with the State. Kiki offered the assistance of the transgender community on the State and local processes for gathering research. In closing, she asked to be kept apprised of the status of the study.

5. MEMBERSHIP UPDATE

Valerie announced that the last HPPC membership slots were being filled. She said that the call had gone out for:

- HIV-positive women (preferably of color);
- Asian/Pacific Islander youth (preferably under 24); and
- African-American gay-identified men (preferably under 30).

The Council is charged with filling its vacancies on a quarterly basis, and is coming up on a new quarter now. Valerie asked that members contact any friends or colleagues who might be qualified and interested. Valerie Kegebein (554-9023) and Betty Chan Lew (554-9492) at the AIDS Office will furnish the nomination forms to those requesting them.

6. UPDATE FROM COMMUNITY PLANNING CO-CHAIRS MEETING IN ATLANTA

Ana Claire and Valerie briefly described this conference, which they had attended along with AIDS Office staff member Brian Dobrow. Valerie called the conference well-organized and well-attended. Since Valerie and Ana Claire had attended different workshops, they had somewhat different experiences of the conference.

Valerie said that she had had an opportunity to compare the San Francisco process with other local planning processes, and had learned that (1) San Francisco is well ahead of many jurisdictions, though not ahead of all of them; (2) most of the cities' public health departments actually do resource allocations (deciding the specific amounts of money to go to particular populations or

interventions), and the HPPC can benefit from information on how they have done it; and (3) for putting out RFPs, the HPPC is behind the other planning groups, which are now in the implementation phase. With regard to evaluation, most jurisdictions and the CDC are largely looking at process evaluation data, but are moving toward collecting behavioral impact data. Other planning groups and the CDC have requested HPPC materials on standard variables for the collection of behavioral change data.

Ana Claire and Valerie had attended an advocacy/lobbying workshop together. While DPH staff cannot do advocacy or lobbying, CBOs can generally do advocacy (if not lobbying as well). Valerie said that providers will have to begin seriously writing to their local, state, and national representatives to inform them of prevention needs and priorities. Government officials tend to respond more to unique (individually written) letters than to uniform letters sent out in bulk. Valerie said that, with the election coming up, the Council will notify members of opportunities to write and/or sign letters to their representatives.

In response to a question from Jimmy Naritomi (who said that his agency's funding prohibits staff from lobbying), Ana Claire distinguished between advocacy and lobbying. Anyone may do lobbying as an individual outside of his/her role in an organization. Many agencies only allow for advocacy to be done in their name, since advocacy consists in letting a government representative know who the advocate is, what he/she does, and what he/she needs or values. Advocacy does not specifically point a legislator in a particular direction. Ana Claire recommended advocacy as an approach that is appropriate for people operating under agency restrictions.

Ana Claire mentioned that she had also attended a workshop addressing the strengths and needs of community co-chairs.

7. COMMUNITY CO-CHAIRS NOMINATION PROCESS

Ana Claire then made a request for nominations for a new community co-chair to the HPPC. The AIDS Office has circulated a list of the people eligible for nomination (new Council members, who will be with the Council for two years). Ana Claire said that she and Valerie would like to receive the nominations by Tuesday, March 19th, so that they can distribute the list of nominees to the Council by about March 23rd. This would allow for ballots to be returned and tabulated at the April 11th Council meeting.

In response to a comment from Chata about the usefulness of bio sketches for the nominations process, Ana Claire asked that members include their own biographical sketches with their nominations. Valerie put out a renewed general call for bio sketches, from all those who have not yet submitted theirs. John Hamilton asked whether members could check to see if their bio sketches had been received, and Valerie answered that, yes, they could call Betty Chan Lew (554-9492) to get a list of bio sketches filed at the AIDS Office. *UPDATE: The AIDS Office has sent a notice to all HPPC members requesting their bios.*

Roles and Responsibilities of Community Co-Chair:

- Two-hour weekly co-chairs meeting
- Steering Committee meetings (The duration and frequency of these have yet to be decided.)
- Assistance with the planning of Council agendas
- Attendance at the yearly CDC Community Planning Co-Chairs conference in Atlanta

Valerie described the co-chair role as an opportunity to get more familiar with the workings of the Council, the DPH, and city processes. She said that the community co-chairs bring their experience and expertise to bear on the planning process, and in turn gain a meaningful experience that may take them in new directions.

8. BREAK

9. MORE ANNOUNCEMENTS
   - Valerie announced that the CDC will not be expecting multi-disciplinary partnership grants for fiscal year 1997. Funding streams will remain separate for HIV, STDs, and TB.
   - Valerie also reported the following information from New York City: In the likely event that the CDC will continue funding direct-funded organizations, the New York City prevention planning council will locally send such organizations information on the Plan and what will be expected of them when they do have to compete again. Direct-funded CBOs will definitely be funded through September, and possibly through next March. This extension of the funding would be an important consideration for the Resource Allocation and Resource Inventory Committee.
   - Ana Claire announced that Coretta Scott King was the plenary speaker on the first day of the Atlanta Conference, where she talked about discrimination generally and about gay/lesbian rights in particular. Her talk on HIV prevention addressed discrimination and the role of the church and different CBOs. The other plenary speech covered needle exchange programs and what is being done for prevention to IDUs in different areas (such as New Haven).
   - Ana Claire identified the Council's use of behavior groups (instead of communities or identity groups) as a key issue discussed at the conference. She said that there was some misunderstanding of how the behavior groups were composed and of what their purpose was. In her observation, the people who had the greatest trouble with the Council's choice to use behavioral categories were those who came from states with a primarily white population. As an example of why those people may have been confused, Ana Claire pointed out that the MSMs who are not gay-identified tend to be more heavily represented in communities of color.
   - Ana Claire informed the Council that she had been one of two youth co-chairs at the entire conference (the other one is on the Los Angeles planning council). She remarked that the San Francisco Council is fairly unique in its diversity.
   - Liz asked about the total number of planning groups nationally. Valerie answered that there are 58 in California alone, but that she could not say exactly how many there are nationally.
   - Ana Claire said she has a friend who is planning to make a three to five-minute film on HIV prevention. The filmmaker is looking for an idea from a provider, and will then shoot and edit the film and give the provider a copy to use (for free). Anyone on the Council who is interested in working with this filmmaker should contact Ana Claire Meyer.
   - Kristen Clements announced that the AIDS Office is sponsoring a Data Elements meeting on Thursday, April 4th, from 9am until noon in the third-floor conference room. The drive behind this conference came out of HRSA's requirement that CARE-funded agencies report their data in a standard manner. Some agencies have both CARE and prevention contracts, and would benefit from being able to report data in the same way, using the same basic variables for both kinds of contracts. The Evaluation/TA Committee is working with the CARE Council on these data elements, and giving input on the data needs for prevention.
   - Natalie Gutierrez announced the "What About AIDS?" exhibition at the Exploratorium. She said it is beautiful and very interactive. Admission to the Exploratorium is free on the first

Wednesday of every month. Natalie suggested that Council members contact Anne Jennings at the Exploratorium (563-7337), if they have clients who wish to go. Valerie added that the exhibition includes a diversity of information, with a range of types of media, to allow all audiences to learn something about HIV/AIDS. There are also a number of previous Council members on the Wall of Honor, devoted to people who have made outstanding achievements in HIV/AIDS-related fields.

10. COMMITTEE UPDATES

Valerie suggested that members listen to these updates with an ear toward how these decisions relate to their own committees' work.

Resource Allocation and Resource Inventory

Hector Carrillo presented for this committee, which has elected Zwazzi Sowo as its chair. Hector summarized that the committee is working on its task of setting guidelines for funding for the June RFP. Members began this task by discussing which programs to set aside and which not to bid. Hector explained that the committee would next examine whether the RFP should focus on behavioral groups or on interventions, and where to create the cut-off for behavioral groups to be included in the first RFP (e.g., first 3, 4, 5, 6, 7, 8, 9, or all 12 behavior groups).

For making decisions on set-asides and putting programs out to bid, the group used the following criteria:

- ⇒ unique population served;
- ⇒ unique legal or policy circumstances;
- ⇒ unique program;
- ⇒ service is valuable and necessary;
- ⇒ there is already a provider performing the service; and/or
- ⇒ it is unlikely that another contractor could provide the service as well/as successfully.

Using these criteria, the group came up with the following recommendations:

PROGRAM	SET ASIDE	PUT OUT TO BID
Needle Exchange	Yes	No
Forensic AIDS Project	Yes	No
Special Programs for Youth	Yes	No
City Clinic	Yes	No
General Education (w/Hotline)	Yes	Yes
Training	Yes	Yes (but only the CBO piece)
Family Health Clinics	Yes	No
School-Based	Yes	No
CTRPN (confidential)	Yes	Yes

The committee was at this point still discussing what to do with the SFDPH counseling and testing program for inpatients, outpatients, and health providers (who may have been exposed to HIV through their work). *UPDATE: As of March 19th, the committee decided to recommend a set-aside for the SFGH program (since the service was seen as necessary and as serving a unique population), and to recommend that the program go out to bid (since it is conceivable that another provider could run the counseling and testing services at SFGH).*

Members have added their stipulations for the contracts that are not going out to bid. For example, school-based prevention and education will be asked to focus more on serving alternative schools. Even with sole-sourcing, all of these providers will have to rewrite their scopes of work and live up to the recommendations of the Plan.

Epidemiology and Research
Committee Chair Patrick Forte reported. He said that the committee had reviewed relevant epidemiological terms and sources of information (recent and current San Francisco studies). The members were assigned the 300-page 1994/1995 Epidemiologic Profile Chapter as reading for their meeting on March 26. They will be revising the chapter for content (with newer data), structure, wording, and accessibility. Members will also be exploring the options for enabling researchers to release their study results and still publish, and will be making recommendations for future research. Patrick added that he is interested in getting input on the epi-profile from communities such as the homeless, people of color, and bisexuals. He said that it would help to have speakers from agencies to address the committee.

Goals and Objectives and Future Directions
Isabel Auerbach spoke for this committee, which had not yet elected a chair. *UPDATE: At the March 15th meeting, the committee elected Barbara Adler as its chair.* Isabel named the roles and responsibilities of the members (which are the same for members of all committees, and have been listed before), and summarized the committee's immediate tasks: (1) review of the 1994/1995 goals and objectives *(done)* and (2) discussion of the goals and objectives for 1996 *(in process)*. The committee will also be synthesizing the Strategies and Interventions and Priority-Setting Chapters from 1995 -- to determine goals for HIV prevention and objectives for prevention providers for the first RFP, and to lay out the goals and objectives for the CDC application for 1997. Finally, it will develop the 1997 goals and objectives for the HPPC.

Isabel explained that the committee is on an accelerated schedule for the next few weeks, so that it can meet its timeline for tasks relating to the June RFP.

Evaluation and Technical Assistance
Committee Chair Roberto Garcia reported. He summarized the roles and responsibilities attached to committee membership, and then explained that the committee had discussed and approved the needs assessment process of the Organizational Development/Technical Assistance (OD/TA) team. The three-pronged needs assessment examines program design, program evaluation, and overall organizational capacity. The OD/TA team held a meeting on March 12th to orient providers to the needs assessment process, which includes a mail-out survey and a site visit interview. About two-thirds of the 30 agencies chosen for the needs assessment were represented at the orientation, and all 30 agreed to participate in the project (those unable to come to the meeting called to say that they would like to be involved). Roberto announced that the next committee meeting was scheduled for March 28th from 2-6pm, at the City Clinic Annex (1360 Mission St., 4th Fl.).

Linkages
Vice-Chair Mark Peppler spoke for this committee. He introduced Chata as the committee chair, and joked that Chata's first official action had been to delegate this presentation to him. Mark reviewed the roles and responsibilities, and then summarized the four areas of linkage to be examined by the committee: collaboration, coordination, referral, and continuum (of care). Members will be working on recommendations for client tracking and quality assurance. The committee has already discussed available sources of information on collaborations, and has been

assigned collaboration readings. Chata added that the committee would probably ask members for input on their experiences with collaborations, or on their decisions against participation in a collaboration. Currently, there are four HIV prevention collaborations funded for San Francisco. Chata went over the funding and the participating agencies for each (see the attached description, from the Linkages minutes).

Membership
Committee Chair John Hamilton reported that the membership committee had not yet had its first full meeting, but had one scheduled for March 19th. He explained that the agenda for this first meeting would focus on guidelines and procedures for the committee.

Valerie asked whether any of the committees had added roles or responsibilities to their original set. The only changes mentioned were the Vice-Chair/backup role for the Linkages Committee, and the responsibility of the Membership Committee to review the evaluation forms for Council meetings.

11. PROCESS EVALUATION TEAM PRESENTATION
Dr. Kathleen Roe presented the results of the forms that members had filled out at the last meeting. Her team distributed the "Evaluation Results" handout with members' written comments on the back, and the "Year 3 Member Background Experiences" handout.

Dr. Roe said that the Evaluation Team will be giving back the evaluation form information (and other information requested by her group) as soon as possible to the co-chairs, consultants, AIDS Office staff, and (when applicable) committee chairs. This way, the information can be used immediately for the planning of agendas and facilitation.

She read through the second handout, calling attention to those background experiences -- such as work in CBOs, loss of loved ones/friends/colleagues/aquaintances to AIDS, experience with large group discussions and decision-making, TA provision, and collection of program data -- that particularly distinguish the San Francisco Council from other planning councils. She also spoke about the experiences at the bottom of the list (those for which 27% or less of the Council had a great deal of experience) as training needs for the HPPC.

Dr. Roe then asked members to fill out sections I. and II. of the evaluation forms that were circulated at this meeting. She described the Evaluation Team as a "while-you're-in-it" shadow. Evaluators will attend committee, co-chair, and steering meetings. They have the advantage of some distance from the Council process, and will be available to help bridge communications. They will be watching for HPPC participants' interactions and moods, and how they change over the course of the year.

In response to a question from Jay Seward, it was clarified that the Evaluation Team does have a formal relationship with the Membership Committee. This committee will need to review the evaluation reports for issues relating to by-laws, procedures, and member recruitment and retention.

12. ADJOURNMENT
As the co-chairs adjourned the meeting, Valerie announced her appreciation of the high attendance at this year's meetings. She thanked members for their commitment, and encouraged them to keep it up in the coming months.

Enclosed with These Minutes:

For those absent at this meeting

- Letter from the Coalition on Bisexuality and HIV Education and Prevention
- "Evaluation Results: Member Evaluation of 2/15/96 HPPC Meeting"
- "Evaluation Results: Year 3 Member Background Experiences"
- Meeting evaluation form, with an additional section for evaluation questions about perceptions of committee meetings and of the HPPC process thus far
- "Participant Dialogue" form

For all members:

- March 14th Agenda, with information on the upcoming Council and committee meetings
- Flyer for the March 21st forum on speed use in the queer community
- Information and application forms for the Price Fellowship for HIV Prevention Leadership
- One-page summary of the prevention collaborations currently funded by the AIDS Office
- Flyer and forms to complete for the California HIV Prevention Social Marketing/Media Campaign workshops
- Flyer (provided by Council member Chandra Pugh) for an HIV prevention fair being held on April 12th in San Francisco's Dolores Park

Next HPPC Meetings:

- April 11, from *3-6pm* at the First Unitarian Church (1187 Franklin St. @ Geary)
  Please note the change of time to accomodate a large agenda. The meeting *will begin* at 3:00.

- May 9, from 4-6pm at the First Unitarian Church (1187 Franklin St. @ Geary)

HIV PREVENTION PLANNING COUNCIL MEETING

April 11, 1996
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

❀❀❀ *SPECIAL NOTE: THIS MEETING IS STARTING AT 3 PM.* ❀❀❀

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Meeting called by:	**Co-Chairs:**
	Valerie Kegebein
/96	Ana Claire Meyer
Please read:	Minutes of March 14, 1996; committee minutes
Please bring:	Entire package, applicable committee meeting minutes

Agenda

1.	Welcome & Introductions (Get Acquainted Exercise)	Ana Claire Meyer	3:00-3:20 PM
2.	Minutes	Ana Claire Meyer	3:20-3:25 PM
3.	Announcements (Co-Chair Nomination)	Valerie Kegebein	3:25-3:35 PM
4.	Robert's Rules & Operating Procedures	Brian Dobrow	3:35-3:45 PM
5.	Public Comment	Ana Claire Meyer	3:45-3:55 PM
6.	***Committee Reports***: Resource Allocation/Resource Inventory - Vote	Zwazzi Sowo	3:55-4:25 PM
7.	Break		4:25-4:35 PM
8.	Goals & Objectives and Future Directions - Vote	Barbara Adler	4:35-4:50 PM
9.	Linkages	Ronnie Ashley (Chata)	4:50-5:05 PM
10.	Evaluation and Technical Assistance	Roberto Garcia	5:05-5:15 PM
11.	Epidemiology and Research	Patrick Forte	5:15-5:25 PM
12.	Membership	John Hamilton/Brian Dobrow	5:25-5:35 PM
13.	Evaluation	Christina Goette	5:35-5:45 PM
14.	Adjournment	Ana Claire Meyer	5:45-5:50 PM
15.	Steering Committee	Committee Chairs	5:50-6:00 PM

NEXT MEETINGS:

For meetings at the AIDS Office, please always check in with the receptionist on the 5th floor.

HPPC - May 9, 1996, 4:00-6:00 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary).

SF Public Health
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4/11/96

HIV PREVENTION PLANNING COUNCIL
MINUTES
April 11, 1996

Members Present:
Barbara Adler
Ronnie Ashley
Isabel Auerbach
Christine Edwards
Patrick Forte
Roberto Garcia
Ellen Goldstein
Fernando Gomez-Benitez
Natalie Gutierrez
John Hamilton
Liz Highleyman
Valerie Kegebein
Sacul L'Adnbre
Marvin Lee
Chinyere Madawaki
Ramon Martinez
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Chandra Pugh
Bethsaida Ruiz
Terry Ryan
Sandy Simms, State Office of AIDS
Zwazzi Sowö
Joshua Volle
Hank Wilson

Members Absent:
Hector Carrillo
Michael DeMayo
Dominic Perez
Jay Seward
Joshua Tager
Edward Zold

AIDS Office Staff:
Kristen Clements
Gene Copello
Brian Dobrow
Lyn Fischer-Ponce
Delia Garcia
Tracey Packer
Billy Pick

Polaris, Inc./Harder + Co.:
Mary Irvine
Lyn Paleo
Eden Tanovitz

Evaluation Team:
Cindy Berenstein
Christina Goette
Kevin Roe
Charles Smith

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Guests:
Carol Badran, WEDGE
Michael Baxter, SPY
Anne Marie Benedicto, Asian AIDS Project
Tamara Ching, Consultant
Wayne Davis, HI-FY
Rene Durazzo, SFAF
Christine Geoghegan, City Clinic
Crystal Jang, SFUSD
Irene Malone, YGC
Shivaun Nestor, WEDGE
Dale Frett, Cole St. Clinic
Liz Rojas, SFDPH
Kiki Whitlock, Asian AIDS Project
Wendy Wolf, City Clinic

1. WELCOME AND INTRODUCTIONS (Get Aquainted Exercise)
Co-Chairs Ana Claire Meyer and Valerie Kegebein convened the meeting just after 3pm. Valerie introduced Gene Copello, who has replaced Dr. Jan Gurley as chief of Health Services and Prevention for the AIDS Office.

A quorum was achieved in the first few minutes of the meeting. Ana Claire facilitated a getting-to-know-you exercise for people present. Everyone was directed to talk with the person on their right, and to find out something about that person that most people don't know. Then each pair or set of people reported back to the group on what they had learned about each other.

2. MINUTES OF 3/14/96
The minutes of the last full Council meeting were approved. However, the author of the minutes would like to correct an omission on her part: the Polaris, Inc. and Harder and Co. consultants were present (Mary Irvine, Lyn Paleo, and Eden Tanovitz), as was Christina Goette of the Evaluation Team (she arrived toward the end, with Kathleen Roe).

3. ANNOUNCEMENTS

- Valerie announced the distribution at this meeting of a DPH memo/policy statement /instruction sheet (enclosed for those absent) on the Reality condom, also known as the female condom. The condom was designed for women to use for vaginal intercourse, but may also be worn by the receptive partner for anal sex, to prevent HIV/STD transmission.

- Valerie asked members for their patience in making time for extra meetings needed in April and May. There will be a second April HPPC meeting on the 25th, as well as meetings on the 9th and the 23rd of May. Valerie said that she was still unsure as to whether there would be one or two HPPC meetings for June.

- Valerie also distributed a handout on advocacy and lobbying, with lists of the names and titles of elected officials. The handout contains information that was shared at the Atlanta Co-Chairs Meeting.

- Ana Claire announced that there had been a change in the agenda, so that public comment would precede Brian Dobrow's presentation on HPPC operating procedures.

- Chandra re-announced the HIV prevention fair being held on April 12th in Dolores Park. For those who did not already receive copies of the flyer (which was distributed with the March 14th minutes), she had extra copies available.

4. PUBLIC COMMENT
Ana Claire briefly explained that people wishing to give public comment should:

1) Write their name and their topic on an index card (made available by the AIDS Office); and
2) Make their comments when called, keeping to a two-minute speaking time.

She said that public comments would operate on a first come, first serve basis. Speakers would be given a 30-second warning before the expiration of their speaking time.

Shivaun Nestor spoke on the topic of funding for school-based education. She told the story of a boy who had had a difficult time coming out and who was sexually active in middle school. She

made the point that school-based education is necessary for reaching all in-school youth, regardless of identity. She added that the WEDGE had built trust and positive working relationships with the schools and CBOs. She was concerned about the possibility that the WEDGE could be de-funded, and that school-based education might then be left in the hands of individual teachers and other school staff. In closing, she read a teacher's letter in support of the WEDGE.

Carol Badran also spoke on the WEDGE program. She expressed concern that the committee's recommendation that school-based education focus more on alternative schools could have unintentional and detrimental effects on prevention for in-school youth. She said that middle-school and high-school-age youth are at risk for HIV, but often do not realize it. She then read a young woman's letter in support of the WEDGE, and closed by saying that the WEDGE is part of a concerted effort to reach youth and that HIV incidence among in-school youth in San Francisco has been going down recently.

Irene Malone introduced herself as a teacher at the Youth Guidance Center (YGC), and said that she was concerned about the future of funding for the WEDGE program. She stressed the importance of reaching youth while they are still in school, and before they end up at YGC. She read letters written by her students, on the importance of the WEDGE program.

Wayne Davis introduced himself as a member of the Health Initiatives For Youth (HI-FY) staff. He said that, for four or five years, he has also been a speaker for the WEDGE program. He has been to many alternative and mainstream schools with the WEDGE, as well as to many youth projects. He described the WEDGE as a comprehensive program, and closed by saying that a de-funding of the WEDGE would have a ripple effect on its collaborating agencies.

Anne Marie Benedicto also spoke for the WEDGE. She works for the Asian AIDS Project, and was invited by the WEDGE to provide culturally-specific services at YGC for Asian/Pacific Islander youth (which account for approximately 15% of the youth there). She noted that the arrival of these youth at YGC is often the first time that they access any care. It is the first chance for many Asian/Pacific Islander youth to get hooked into services. The WEDGE, she explained, is very strongly linked with various culturally-specific organizations.

Tamara Ching spoke as a member of the California Planning Working Group, which conducts HIV prevention planning at the state level. The CPWG meetings involve members of the State Office of AIDS and their HIV prevention contractors. Tamara announced that a forum on transgender discrimination will be held by the CPWG on May 23rd. The time and the location are still to be announced, but the forum will take place in San Francisco. Tamara described the CPWG as willing to work with the transgender community to establish appropriate variables and criteria. Kiki will distribute a notice on the precise location and time of the forum, when this information is made available by the State Office of AIDS.

Rene Durazzo of the San Francisco AIDS Foundation addressed the Council's deliberations on funding and bidding for the San Francisco Hotline. The SFAF has run and operated the Hotline since the mid-1980's, in tight coordination with the State Hotline. Renee described the integration of the two hotlines as seamless (in terms of shared training, resources, and volunteer recruitment). He pointed out that the State has decided to continue the existing contract for the Northern California Hotline. Renee wanted the Council to be aware of this decision, and to consider its implications for the San Francisco Hotline. He was concerned about the potential duplication of services, should the local and regional hotlines be operated by two separate providers. He was also

concerned that a separate local hotline might not be able to work up to the capacity of the current contractor. Finally, he suggested that the Council review the reports that the AIDS Office has on the functioning and activities of the San Francisco Hotline.

Michael Baxter of Special Services for Youth said that he would be available to answer any questions on the current MOU that SPY has for provision of HIV prevention services at YGC.

Discussion/Clarification:
Hank Wilson asked what was the context of the public comments that had just been offered. He wanted to know whether decisions on funding or de-funding were to be made at this time. Valerie explained that funding cuts and continuance were not up for discussion at this meeting. The HPPC agenda included a discussion of the Resource Allocation and Resource Inventory Committee's recommendations for set-asides and for competitive bidding. The question of increased, decreased, or level funding for the set-asides had not yet been addressed by the committee. Finally, any intervention that the HPPC decides to put out to bid may still be awarded to the current contractor, if that contractor can demonstrate to a review panel that it is still the most appropriate provider for the service.

5. ROBERT'S RULES OF ORDER & OPERATING PROCEDURES
Brian Dobrow had distributed a summary handout on Robert's Rules. He read through most of this two-page handout with the Council. (This handout is enclosed for those unable to attend.)

In response to a member's question about what would be involved in a "motion to suspend the rules," Brian gave the example of the rule that only Council members may speak on an issue when it comes to a vote; the Council has the power to suspend this rule, in order to hear from members of the public. He explained that the rules exist to support the functioning of the Council, and not to stifle discussion or create problems. He said that, as long as the Council follows the basics, with the co-chairs to uphold the rules, then the group should be able to continue to function effectively.

Brian added that, if any member has a specific question about the actions taking place in Council, then he/she may call a temporary stop to the discussion, to get clarification. Members should not be afraid to ask for a "point of order." Hank added that members should not make uninformed motions; they should try to be sure of exactly what is at stake, before moving to a vote. He also noted that, at some time in the future, members will be able to look at the existing Council rules and make some changes (the Membership Committee will make recommendations on the by-laws).

6. BREAK

7. CO-CHAIR NOMINATIONS
The two nominations made so far for the second community co-chair position were for Chata (Ronnie Ashley) and Roberto Garcia. The co-chairs asked if anyone wished to make an additional nomination at this juncture. Zwazzi nominated Patrick Forte, but Patrick was unable to accept due to other commitments. At this meeting, the nomination process was closed, and Valerie called for the nominees' biographical sketches and statements addressing the points in the letter distributed previously to the HPPC (on the community co-chair position). The bios will soon be faxed or mailed to the HPPC membership, in time for the election on April 25th. Since the by-laws have no provision for an absentee ballot, members are encouraged to make any efforts necessary to attend this next meeting.

8. COMMITTEE REPORTS

Resource Allocation and Resource Inventory Committee

Because Chair Zwazzi Sowö had had to miss some recent meetings, Jimmy Naritomi presented the recommendations made by this committee. He first explained the committee procedures around decision-making: a quorum of one-half of the committee membership plus one is required for any formal decision-making. When consensus cannot be reached, the committee can move forward on a majority vote, which requires one-half plus one (or one-half plus one-half, when an odd number of people is present) of the members present to agree.

Jimmy told the Council that the committee had not yet addressed the actual funding allocations for set-asides. The committee has discussed looking generally at whether to increase funds, decrease funds, or keep funds level for the set-asides. The last page of the Resource Allocation handout explains some of the committee process for determining funding priorities.

Jimmy explained that some of the committee decisions had required much more discussion than others, and that there had been some close votes and serious consideration of dissenting opinions. He very briefly noted determining factors in the decisions made on each set-aside (e.g., **Needle Exchange:** unique policy circumstances, or **Special Programs for Youth** and **Forensic AIDS Project:** unique working relationships and rapport established with the correctional authorities and the target populations). Then he asked how comfortable people on the Council would be with taking a vote on the block of committee recommendations.

Discussion:

Fernando asked whether the criteria for set-asides were the same criteria used to make bidding decisions. Ana Claire responded that the third and fourth bulleted criteria in the handout related more specifically to the bidding decisions (whether or not to sole-source a contract). John asked who would review the proposals, for those interventions going out to bid. Valerie replied that the AIDS Office will constitute an independent review panel, and that its members will have been screened for any possible conflicts of interest.

Hank wondered whether the decisions not to put certain contracts out to bid indicated that there were no perceived problems with those contracts currently. Jimmy and Lyn Paleo explained that members of the committee had been writing down stipulations for the sole-sources, and that these stipulations will go into the contract negotiations. Continuing contracts will still have to show that they can meet the requirements of the Plan. Everyone will have to make some changes, in response to the priorities established by the HPPC. Likewise, the decisions to put some interventions out to bid were not based on unsatisfactory evaluations of the current contractors. The committee instead considered whether another provider would be able to provide the service as effectively as the current provider can.

Joshua Volle asked for clarification on what was included in General Education and in Training. In response, Valerie said that there should be some general education available for all populations, and that general education could include various forms of media and social marketing (targeting specific or general populations), as well as the hotline. She said that the training contract would include the standard counseling trainings, and could include other forms of training as well (such as sensitivity trainings for working with different target populations). The piece discussed by the committee is currently provided by a community-based organization, but would not necessarily have to be provided by the current CBO contractor, in order to be successful.

Ellen expressed her profound discomfort with voting on the block of recommendations. She felt that members would need to understand more of the reasoning behind the committee's decisions. Fernando agreed with her position, and Roberto eventually asserted that there seemed to be consensus that the group was not ready to vote. Jimmy and Valerie stressed the need to condense many hours of committee work into a short presentation format, and Jimmy added that the committee may have erred on the side of oversimplification. John stated that the committees had been formed for the very reason that the material to be covered this year cannot be covered in proper detail by the Council as a whole. He said that the Council should be addressing any major problems in the committee process, but that there should be some basic trust in the deliberations and decisions of this subset of Council and community members.

Jimmy reminded the Council that the upcoming June RFP only accounts for CDC funds, and will not have to cover all prevention activities. The next RFP, which includes State and General funds, can be designed to fill in any gaps left by the June RFP.

Ellen maintained that this was a major turning point for the Council, which had not yet been asked to make CBO-specific, contract-specific decisions. She was concerned that members were being asked to determine something outside of the actual Plan, without being given the necessary information. She objected not only to making funding decisions at this stage, but to choosing set-asides from what she identified as a strange mix of activities and venues (which appeared to stray beyond the HPPC behavioral focus). Lyn Paleo responded to Ellen's comments by saying that she had touched on the precise reason why the Council had to make this decision first. The set-asides represent the exceptions to the general HPPC process, of setting prevention priorities by behavioral risk, co-factors, and appropriateness of interventions. The Resource Allocation and Resource Inventory Committee is charged with determining how much funding will be left (to put out in the RFP) *after taking out the necessary funding for set-asides*. The committee had to examine which prevention interventions would definitely be needed as continuing services to their target groups. Valerie added that the committee was not suspending the rules for these contracts, even though they represent the exception to the norm. Within the set-aside programs, there will be a requirement that the providers focus on the particular risk behaviors of their target populations.

At this point, Jimmy made a motion to vote on the committee decisions as a block. His motion was seconded. Hank pointed out that this would encourage him to vote "no" on the entire package, because he disagreed with one or two of the specific items included (i.e., the bidding of the hotline and of the citywide street outreach collaboration). He argued that, if there isn't a problem with the existing contractor, there is no reason to spend staff time and energy on the bidding process. Ana Claire told the HPPC members that they could vote on the package as a whole, and still vote on separate amendments to the package. Ellen received clarification from committee members that there may be more than one provider for each set-aside category.

<u>The Vote</u>

Motion: To accept the set-aside and sole-sourcing recommendations of the Resource Allocation and Resource Inventory Committee (no amounts specified).

In Favor: *6*
Opposed: *9*
Abstentions: *10*

The motion failed to carry.

Liz made a motion to vote on each separate set-aside category, but there was no second to the motion.

Valerie asked the Council membership to give the committee some guidance, as to which issues should be discussed in greater detail. Terry asked if it would be feasible to get some information on what each of the set-aside programs is doing, and for whom. Lyn Paleo offered to put out a background document, briefing the Council membership with three or four sentences on each program: its services, its client population, and factors in the decision made by the committee.

Fernando stressed the importance of discussing the specific determining factors for bidding decisions (why some programs are going out to bid, while others aren't). He explained that this is the kind of decision that could be misunderstood in the community outside of the HPPC. Fernando felt that it would be necessary to take steps now to prevent misinformation and misinterpretation.

The Council reached consensus to wait for the document Lyn would compose (describing program services, program client populations, and the "pros" and "cons" of putting a particular program out to bid), before taking another vote on the committee recommendations. In addition to this measure, Lyn asked that those with strong opinions on certain set-asides or bidding decisions fill out the table (shown in the handout) with their own recommendations. This feedback should be turned in to Lyn Paleo (fax: 522-5445) before the next Council meeting.

Valerie called a vote to determine whether members of the Council had philosophical differences with the whole concept of doing set-asides.

The Vote

Motion: To create some set-asides for prevention funding for 1997.

In favor:	*21*
Opposed:	*0*
Abstentions:	*3*

The motion carried. Summary information will be going out to members as soon as possible.

Ana Claire checked with members present about who would be able to stay beyond 6pm. Not enough members could stay to make a quorum, so the meeting time was not extended. As a result, some of the committee reports had to be postponed until the April 25th meeting.

Goals and Objectives and Future Directions Committee

Committee Chair Barbara Adler presented the recommended goals and objectives for the 1996 HPPC. She distributed a handout drafted by the committee with Eden Tanovitz, the technical support person. Barbara explained that the committee had followed the CDC format for writing up goals and objectives (with separate outcome, impact, and process objectives). Drawing the Council's attention to the places where the committee chose particular numbers, rates, or percentages, Barbara said that the committee had striven for a realistic approach that would still set goals for significant and measurable change. She explained that the committee would bring a draft of broad HIV prevention goals and objectives to the next HPPC meeting in April.

Discussion:

Jimmy asked if the committee had thoroughly considered whether these objectives could be attained in the time frame allowed (see the dates given in the handout). Barbara responded that the committee had shifted around the numbers, rates, percentages, and dates several times, in order to

ensure that the objectives were reasonable. Terry asked how the committee chose 2003 as the expected time of completion for the outcome objectives. Tracey explained that the end of the year 2002 (suggested in the language, "By the year 2003..."), represents the close of the sixth year of funding under the new Plan (January 1997-December 2002). Ana Claire pointed out that the year 2003 also corresponds with the end of the second funding cycle. The committee viewed this as a reasonable period of time for all San Francisco providers to have come into full compliance with the Plan, and for the implementation of the Plan to show measurable results in the health outcomes and referral outcomes of the population of San Francisco.

Mark asked (regarding the third outcome objective) if everyone receiving CTRPN services would have to be given a referral, in order to meet these objectives. Barbara clarified that only those clients assessed as needing referral would be referred to other services, and that they would be referred in a manner appropriate to their needs and requests. Mark also asked whether the system of documentation of referrals for high-risk negatives (the last process objective on page two of the handout) was a reasonable expectation. Tracey responded that this objective refers to what the Linkages Committee will do (with the approval of the HPPC) to assist providers in the tracking of referrals. It is the recommendations, and not the actual system for documentation, that will have to be ready by the end of the year.

Council Members' Suggested Amendments to the 1996 HPPC Goals and Objectives:

1) The language of objectives should clarify that the committee makes recommendations to the AIDS Office through the HPPC, and not on its own authority. The HPPC finalizes the decisions made within committees, before those decisions can affect prevention services.

2) The second outcome and impact objectives need to be revised for feasibility:
    a. The expected percentage of individuals reducing their high-risk behaviors should be somewhat lower than 100%.
    b. The percentage by which they reduce their risk behaviors should be made somewhat lower than 75% (perhaps through the use of a range).

<u>The Votes</u>

Motion: To make amendment #1 above apply to the 1996 HPPC Goals and Objectives.
In Favor: *All present.*
The motion was unanimously approved.

Motion: To make amendment #2a above apply to the 1996 HPPC Goals and Objectives.
In Favor: *16*
Opposed: *4*
Abstentions: *1*
The motion passed.

Motion: To make amendment #2b above apply to the 1996 HPPC Goals and Objectives.
In Favor: *20*
Opposed: *1*
Abstentions: *2*
The motion passed.

Motion: To accept the 1996 HPPC Goals and Objectives, with the above amendments.
In Favor: *All present.*

With the addition of the Council members' amendments, the committee's recommendations for 1996 Goals and Objectives for the HPPC were unanimously approved.

Presentations for the Linkages, Evaluation and Technical Assistance, Epidemiology and Research, and Membership Committees were postponed until the next April HPPC meeting. See the enclosed outline for the Linkages Committee recommendations on collaboration.

Attached with These Minutes (for those absent):

- Reality condoms memo from the SFDPH
- Notes on advocacy and lobbying, from the Atlanta conference for co-chairs
- "Robert's Rules of Order" outline
- Summary of issues addressed by the Resource Allocation & Resource Inventory Committee
- 4/11/96 Draft of Goals and Objectives for the 1996 HPPC
- Background Experiences Questionnaire, to be returned to Dr. Roe
- Evaluation Results (from 3/14/96)

Attached for All Members:

- Linkages Committee update
- HPPC Participant Dialogue boxes for process evaluation*
- Calendar of upcoming HPPC-related meetings and trainings

Note: Additional documents from the committees, along with the co-chair nominees' statements and bios, are being sent out separately from the AIDS Office to the Council membership.

Next Meeting: Thursday, April 25th, from 4-6pm at the First Unitarian Church -- 1187 Franklin

Minutes Recorded by: Mary Irvine
Minutes Approved by: Valerie Kegebein and Lyn Paleo

* If you attended this meeting and haven't yet filled these out for April 11th, please complete the copy enclosed, and return your responses to Christina Goette or another Evaluation Team member at the meeting on April 25th (or by fax or mail, if you cannot attend this HPPC meeting).

HIV PREVENTION PLANNING COUNCIL MEETING

April 25, 1996
4:00 PM to 6:05 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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REVISED

Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer

Please read: Agenda, minutes of April 11, committee minutes, Co-Chairs bios, committee reports/faxes from the AIDS Office and Polaris

Please bring: Entire package, applicable committee meeting minutes

Agenda

1.	Welcome & Introductions	Valerie Kegebein	4:00-4:10 PM
2.	Minutes	Valerie Kegebein	4:10-4:15 PM
3.	Announcements	Valerie Kegebein/Members	4:15-4:20 PM
4.	Public Comment	Ana Claire Meyer	4:20-4:40 PM
5.	Co-Chair Selection	Ana Claire Meyer	4:40-4:50 PM
6.	*Committee Reports:* Steering	Ana Claire Meyer	4:50-4:55 PM
7.	First & Second Year Planning Recommendations	Lyn Paleo	4:55-5-05 PM
8.	Goals & Objectives - Concept Vote	Isabel Auerbach/Tracey Packer	5:05-5:20 PM
9.	Evaluation & Technical Assistance - Concept Vote	Roberto Garcia/Kristen Clements	5:20-5:40 PM
10.	Resource Allocation/Resource Inventory - Update	Jim Naritomi	5:40-6:00 PM
11.	Evaluation	Members	6:00-6:05 PM

NEXT MEETINGS:

For meetings at the AIDS Office, please always check in with the receptionist on the 5th floor.

HPPC - May 9, 1996, 3:00-6:00 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary).

HPPC - May 23, 1996, 3:00-6:00 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary).

Please note: Due to the amount of information to be discussed, we need to add another hour to the meetings in May. We appreciate your patience and endurance.

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HIV PREVENTION PLANNING COUNCIL MINUTES

April 25, 1996

Members Present:
Ronnie Ashley
Isabel Auerbach
Hector Carrillo
Christine Edwards
Patrick Forte
Dale Frett
Roberto Garcia
Ellen Goldstein
Fernando Gomez-Benitez
Natalie Gutierrez
John Hamilton
Liz Highleyman
Valerie Kegebein
Sacul L'Adnbre
Marvin Lee
Ramon Martinez
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Chandra Pugh
Bethsaida Ruiz
Terry Ryan
Hank Wilson

Members Absent:
Barbara Adler
Michael DeMayo
Chinyere Madawaki (came but left before meeting began)
Dominic Perez
Jay Seward
Sandy Simms
Zwazzi Sowo
Joshua Tager
Joshua Volle
Edward Zold

AIDS Office:
Kristen Clements
Brian Dobrow
Tracey Packer

Evaluation Team:
Christina Goette
Kevin Roe

Polaris, Inc./Harder + Co.:
Mary Irvine, Polaris, Inc.
Lyn Paleo, Harder + Co.
Eden Tanovitz, Harder + Co.

Guests:
Jonathan William Brown, Brothers Network
Eileen Hansen, Women's AIDS Network
Vic Hernandez, community health outreach worker and researcher
Robin Ortiz, AHP
Michael Ross, WEDGE Program
Gregory Walker, Brothers Network
Kiki Whitlock, AAP, TGCTF, LABTAC/HRC

1. WELCOME AND INTRODUCTIONS

Valerie convened the meeting a few minutes past four. As members introduced themselves, a quorum was achieved.

2. APPROVAL OF MINUTES

The minutes of April 11th were approved with one correction, from Ellen Goldstein: Ellen's comment in response to the Resource Allocation Committee presentation was that she had understood that the HPPC would not be making contract-specific funding decisions *at all* (as opposed to "not yet").

3. ANNOUNCEMENTS

Valerie made three announcements:

- Valerie thanked Zwazzi Sowo for her time serving as the committee chair for Resource Allocation and Resource Inventory. Zwazzi had since had to step down from this role, in order to fulfill her other commitments. Valerie welcomed Jimmy Naritomi as the new chair of this committee.

- There will be an extra hour required for both of the May HPPC meetings, to meet the requirements of fuller agendas. Please arrive before 3:00pm on May 9th and May 23rd, since those meetings are expected to take a full three hours.

- Valerie thanked members for their feedback, both in the Council meetings and in the evaluation forms created and distributed by the Process Evaluation Team.

4. PUBLIC COMMENT

Ana Claire Meyer quickly reviewed the procedure for public comment.

- *Gregory Walker*, the program director of Brothers Network, expressed his concern about the apparent dearth of African-American Council members. He said that his program specifically addresses the needs of African-American gay, bisexual, and transgender people in San Francisco. He noted his pleasure at seeing two new African-American members on the Council today, and closed by stressing the higher rates at which African-Americans are dying of AIDS.

- *Michael Ross*, of the WEDGE Program, began by announcing that WEDGE staff members are going to be attending the HPPC meetings more often, in order to help the Council understand the value of this prevention program. He said that the WEDGE provides prevention services to the 8th, 9th, and 10th grades in public schools, as well as to youth in alternative schools, private schools, and some out-of-school settings. He proceeded to read letters from students who had received prevention services from the WEDGE program, and who wanted to let the Council know the importance of the program in their lives.

- *Eileen Hansen*, of the Women's AIDS Network (WAN), spoke about the Priority-Setting Chapter risk matrix and ranked list of behavioral groups, in relation to the RFP. She was concerned about the lower risk rankings for female behavioral populations, and what this would mean for funding of programs targeting women for HIV prevention. She explained that she thought providers should be dealing with the epidemic now in a way it wasn't handled in the early years (when gay, white men were the most visible affected population, and there was a delayed public health response to the problem) -- by anticipating the likely areas where future infections will be found. Specifically, she was unsure of why MSM/F-IDU were listed as the second highest-risk population, when FSF/M-IDU (a female population which she described as participating in the same behaviors) were listed as the seventh population. She was also concerned that people of color did not appear as a population at risk, in the Priority-Setting list or matrix. She did, however, thank the Council for its extensive work in prevention planning. She closed by making two requests:
  1) that the Council calendar a discussion of the Priority-Setting list and matrix for behavioral populations, before it develops the language for the RFP; and
  2) that the Council consider the letter, which WAN also supports, from the Women's Positive Care Coalition to the HPPC (see the enclosed).

Points of Clarification Requested by Council Members
Following the public comments above, members asked questions particularly directed to the co-chairs and AIDS Office staff. The information gained in this discussion is summarized below:

- ⇒ There are currently 5 vacancies on the Council, and there have been 9 nominations for new members. The Screening/Selection Committee will meet in the next two weeks, in order to fill the open positions. Of the 9 nominees, the majority are African-American, four are HIV-positive, and just under one-half are youth under 25 years of age. Because of gaps identified in the current membership, a gay African-American male will definitely be represented in the next selections.
- ⇒ Sacul would like to recommend Vic Hernandez to replace Michael DeMayo (both men have strong research backgrounds). However, Michael had not, at the time of this meeting, submitted an official resignation.
- ⇒ When a member is frequently absent from Council meetings, the co-chairs contact that member, to ask whether he/she plans to attend future meetings and stay on as a member. They must wait for a response from the member, and if that member says that he/she will be attending the upcoming meetings, then the co-chairs wait to see if this commitment is met (and ask the member to resign if it is not met).
- ⇒ Ellen invited Eileen Hansen to attend the next Resource Allocation and Resource Inventory Committee meeting, so that she could have some input (as a community member) on the language of the RFP.
- ⇒ Ana Claire noted that the above-mentioned committee will not be revisiting the Priority-Setting process established last year. The AIDS Office will be holding trainings on the Priority-Setting Chapter, though, and these would make a good opportunity for community members wanting a thorough explanation of how the 1995 Priority-Setting Committee arrived at the scores and rankings shown in the behavioral matrix, and of how more specific descriptions of target populations (taking into account ethnicity, race, sexual identification, etc.) fit into the risk scoring process for prevention proposals.
- ⇒ Valerie said she would be willing to call a special meeting to receive community input on the Priority-Setting Chapter. This feedback could then be brought to the committee and the Council level.
- ⇒ Jimmy added that the Resource Allocation and Resource Inventory Committee presentation at this meeting would also address the specific uses of the Priority-Setting process.

5. CO-CHAIR SELECTION
The two nominees for the community co-chair position, Roberto Garcia and Chata (Ronnie Ashley), gave statements about their backgrounds and what they would bring to the role. Next, Cynthia Goette and Kevin Roe distributed and then collected the ballots. Through this process, Chata was elected as community co-chair. Valerie congratulated both men on their nomination and Chata on his selection. She thanked the members present for reading the bio. sketches and voting.

Committee Reports

6. STEERING COMMITTEE
This committee met last Friday (4/19), and all committee chairs were present. They discussed the chairs' needs, and made the following suggestions:

- Committee chairs will receive facilitation training.
- Chairs will offer each other support, in and out of the Council meetings.

- The Steering Committee will create opportunities for chairs to discuss and practice their presentations.
- The committee will also make agenda revisions as needed, to set realistic expectations for Council meetings.
- The chairs will be given a review and clarification of HPPC meeting procedure (e.g., Robert's Rules).
- Chairs will work toward the coordination of different committee tasks (sharing committee ideas and issues).
- The committee will review last year's Council and committee work and how it forms the context for current Council and committee work.
- The Steering Committee will serve as an opportunity for troubleshooting on committee tasks.

The Steering Committee also made one resolution: to **send out a unified packet summarizing the work of the different committees, in advance of HPPC meetings.** (When possible, this packet will be included with the HPPC minutes. Otherwise, it will be mailed out separately.[1])

The meetings of the Steering Committee will take place once each month (except in July), in the week before the first (or only) HPPC meeting for that month.

7. BACKGROUND: 1ST AND 2ND-YEAR PLANNING RECOMMENDATIONS

Lyn Paleo summarized the past work of the HPPC. She explained that she had been asked by Ana Claire and Valerie to give this presentation, since they both need to focus on the business of conducting the meeting. She described the presentation as a reminder of the common threads in the former and current HPPC processes. Referring to the handout she had distributed (enclosed for those absent), Lyn called this document a greatly abbreviated summary of several larger documents, which members received in the form of the draft 1995 Plan and the two additional 1995 chapters.

In Year One, the Council laid out large, fundamental principles for how to approach the epidemic (e.g., through a focus on behavioral groups). In Year Two, the two committees worked on how to apply the principles established in Year One. The current Year Three of the planning process involves a repetition of the issues raised in the first two years, for the revision of past chapters and the creation of new and very specific recommendations on the committee topics. Lyn listed the following issues being revisited this year:

a) the targeting of high risk behavior groups first
b) a call for needs assessments (looking at risk behaviors and co-factors)
c) a need for evaluation and standardized variables for data collection (and specifically, a need for methods of measuring client-level/behavioral outcomes)
d) a need for technical assistance and organizational development (to help providers make the changes required in the Plan)

She said that all of the planning work has been guided by the Council. However, some of the actual work (e.g., literature searches, interviews, and writing) has been performed by the consultants, as directed by the Council and committees. On the back page of the handout, Lyn had listed the different areas of consultant support to the Council, and the participants in each effort.

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[1] Attn. Members: Please be looking in your mail for Epi./Research, TA/Eval., Goals & Objectives, and Linkages Committee updates; and check your faxes for a Resource Allocation/Resource Inventory update.

Lyn then explained the meaning of the *"concept votes"* on today's agenda (and to be included in future agendas as well). The concept votes allow the Council to give a committee feedback on whether the committee work is heading in a generally approved direction. They also create an opportunity for the committee to adjust its recommendations in response to Council input, before the recommendations come back to the Council for a *final vote.* In a concept vote, members can request changes to details in the recommendations, without actually having to block the initial approval. Through this new procedure, the Council will be kept abreast of upcoming decisions to be made on committee work, and committees will be able to make steady progress on their tasks, rather than doing a great amount of in-depth work, only to be sent back to the drawing board.

8. GOALS AND OBJECTIVES

Because Chair Barbara Adler could not attend today, Isabel Auerbach gave the committee presentation. She referred members to the revised 1996 HPPC Goals and Objectives handout distributed at this meeting (enclosed for those absent). The committee had incorporated the Council feedback given at the April 11th meeting.

Concept Vote

The Council unanimously accepted the revised 1996 HPPC Goals and Objectives document.

Next Isabel presented the "Recommendations for Prevention Goals for the 1996 RFP," included in the packet mailed out before this meeting to all members. Isabel noted that the committee had attempted to keep these broad goals as simple and clear as possible. The members had asked themselves, "How can we help providers help us reach our overall goal?" From the written goals produced by the committee, providers should be able to glean how they fit into the overall picture and goal of prevention in San Francisco, as they go about the work of completing their individual pieces (requirements in the Plan). The goals are structured to identify the purpose of each general requirement area (basic format: "Providers will do ----, *so that* (or *in order to*) ----").

Council Feedback[2]

- Ellen said that she would add to Goal #1(c) that interventions might also be changing attitudes, beliefs, or knowledge. She wanted the language to acknowledge that the HPPC might support some interventions that are not behaviorally based. *The committee responded that it would look at ways to clarify and/or expand this goal.*

- Hank expressed his concern about the need to target young, gay people as a group (in order to combat the perception that it is just older gay men who are infected). He added that he was not sure quite how to fit this issue into the goals for the RFP. *Tracey responded that the committee would take up this question in its meeting on the following morning.*

Concept Vote

The Council expressed unanimous support for the direction this committee is taking for prevention goals for the RFP.

[2] In all **Council Feedback** sections, the responses from the committee and AIDS Office staff members will be italicized, to distinguish them from the points and questions raised by Council members who are not on the committee.

9. LINKAGES REPORT (added to agenda by the co-chairs, since the meeting was under time) Chata presented the information in the handout that was sent as an attachment to the last HPPC minutes. He explained that the recommendations would apply to collaborations, in the event that collaboration is the approach chosen by a given provider/set of providers. The handout gives specifications for how a collaboration proposal should look (what it should address or include).

Council Feedback

- Roberto suggested that the recommendations would benefit from a clear definition of agency "autonomy" within the collaboration (regarding fiscal agency and roles of different partners). *Chata gained some clarification on what Roberto meant, and noted his points.*

- Hank asked how the committee would be incorporating information on current collaborations. *Tracey said that the committee had, in part, based its recommendations on the evaluation reports of current collaborations, and on the experience of two committee members involved in collaborations.*

- Hank said that he would like to see some specific direction on the roles of the partners and the AIDS Office, with respect to mediation and problem-solving. He thought that the recommendations should anticipate and address such issues arising for collaborations. *Chata and Tracey noted this point, and agreed to look at expanding the direction under items 8, 9, and/or 11 -- regarding policies and procedures, anticipated challenges, and relationship of partners to the AIDS Office.*

- Roberto asked who would actually decide whether to recommend collaborations. *Tracey responded that the decision rests with the Department of Public Health and the AIDS Office. Mitch Katz is currently reviewing the overall evaluation report on existing collaborations, to determine the importance of recommending prevention collaborations in the next RFP. For now, the committee is simply recommending the elements to be included in the structure of collaborations, should collaboration proposals be reviewed.*

Concept Vote

The Council unanimously approved of the general direction taken by the Linkages Committee.

10. EVALUATION AND TECHNICAL ASSISTANCE

Roberto Garcia explained that the committee (including its consultants) is working on two tasks simultaneously: (1) the needs assessment for organizational development and technical assistance, and (2) the outline for the Data Collection and Evaluation Chapter of the Plan. He described the process for the needs assessment, and then moved on to discuss the chapter outline. The committee has come up with two basic recommendations for data collection, and has determined that the early technical assistance effort should focus on assisting providers in following these two recommendations (regarding collection and reporting of data using standard sociodemographic variables, and performance and reporting of a risk assessment survey). The second recommendation was being presented at this meeting for a concept vote. The committee had agreed that all providers should conduct a *one-time risk assessment survey* of their chosen target populations (preferably at the beginning of the contract period), and should submit the results to the AIDS Office. This survey would serve as an initial needs assessment, and would also have an evaluation purpose (as a baseline for comparison with later surveys, after the target population has received prevention services from the program in question).

Roberto also described the sections that the committee had outlined for inclusion in the chapter (see handout sent in the committee summaries packet). For the section on evaluation definitions, the committee decided to adopt the *process-outcome-impact* format for written objectives (as opposed to process-impact-outcome, which is the other format being used in San Francisco).

Next, Roberto read through the list of questions (enclosed for all members) that the committee is addressing in its work.

Council Input

- There is a typo at the bottom of the second page of the committee document in the packet; this action item should read, "The committee recommends adopting the Process -- Outcome -- Impact terminology."

- Terry asked about how client satisfaction surveys would be incorporated into the recommendations on program evaluation. She felt that these surveys would be an important measure of program effectiveness, and should be included in program evaluations. *Kristen responded that the committee is prioritizing certain recommendations to apply to all providers, for inclusion in the RFP. She explained that other elements of program evaluation would be discussed in the committee, once the RFP priorities had been settled. Ellen added that the committee was initially emphasizing evaluation steps that would lead to an overview of the populations served or missed by prevention services in San Francisco. This approach does not exclude agency use of client satisfaction surveys.*

- Jimmy said that he had no problem with the committee's concept, but was concerned that the terminology might confuse people less accustomed to it. He suggested that separate definitions be written out for process, impact, and outcome. *Kristen explained that process objectives relate to the activities planned for completion by staff members, outcome objectives relate to the smaller and more immediate effects of these activities on the target population, and impact objectives relate to how the smaller outcomes come together to make progress toward the overall prevention goal. Impact and outcome objectives have been used interchangeably (some would describe "impact" as the immediate impact and "outcome" as the greater result for the overall cause of prevention). At this point, the issue is largely one of semantics, and of achieving consistency across agencies in the use of evaluation terms and tools.*

- Hector asked whether the committee was looking at (1) the differences between internal and external evaluation (in terms of bias, and the advantages or disadvantages of each approach), and (2) the different styles or schools of technical assistance (e.g., broader TA delivery or tailored, agency-specific approaches). *Ellen and Kristen said that the committee was trying to help agencies become more expert at internal evaluation. Members had decided to focus current TA at the program level. In the OD/TA contract which is closely attached to this committee, there is some funding for the OD/TA team actually to administer TA -- either intensively to those who need it most, or more generally to a larger set of providers. TA will be delivered in accordance with committee recommendations (as approved by the Council) and AIDS Office recommendations (e.g., from program managers). However, the single OD/TA contract may not be able to provide all of the TA required by providers.*

- Hank asked whether provider feedback on the TA received would be built into the provision of future TA. *Kristen responded that the committee would try to incorporate an evaluation of the TA received.*

- Chata requested some re-thinking of the language around cultural competency (in Section E of the committee questions). He didn't think that people should presume "cultural competency" in any one culture, since cultures are more internally complex and diverse than this language suggests. In other words, it is not possible to "master" a culture as one would master an instrument or a style. *Committee members considered these comments, and asked Chata if he agreed with the term "culturally respectful," as opposed to "culturally competent."* Chata said that this term was preferable. His greater concern seemed to be that the committee should not assume that the needs of each culture could be met with certain, predictable wording changes and question formats.

Concept Vote

The Council unanimously approved of the committee direction and the recommendation of a one-time risk assessment (preferably at the beginning of the contract period), the results of which would be reported to the AIDS Office.

11. RESOURCE ALLOCATION AND RESOURCE INVENTORY

Jimmy Naritomi announced the upcoming two meetings of this committee (see the enclosed, updated HPPC calendar). He thanked Council members for their feedback during and after the last HPPC meeting, on the recommendations of this committee. He then called everyone's attention to the Resource Allocation handout distributed at this meeting. He said that, while this committee has had to incorporate the work of the other committees into its recommendations, it cannot be responsible for justifying or changing this other committee work. The Priority-Setting Chapter rankings and matrix, for example, cannot be revised at this stage and must be understood as a foundation for much of the work of the Resource Allocation Committee this year. Jimmy stressed the committee's decision to allow for proposals from any and all of the 12 behavioral groups, with the stipulation that proposals must demonstrate that their target populations reach a minimum risk score (to be determined), in order to become eligible for consideration. The Plan provides some data on target populations, and this data is available for insertion into the formula (relative risk x behavioral frequency x prevalence) used to produce risk scores of particular target populations. Providers may also submit frequency and prevalence data from other sources on their target population. However, any scores differing from the basic matrix score for a group must be accompanied by supporting data, the validity of which is subject to review by an independent review panel. Programs with the highest valid behavioral frequency/HIV prevalence scores and overall scores will be prioritized for funding in the first round. To the existing criteria determining the overall scores of proposals, one item may be added on collaboration (depending on whether the DPH and AIDS Office decide to *recommend* collaboration).

Jimmy explained that the minimum risk score, determining initial eligibility of proposals, could not be determined by the committee or released yet by the AIDS Office (which will decide on a score), because of the problem of advance knowledge of any information critical to the judgment of proposals. With the second RFP, there will be an opportunity to fill in any service gaps left after the first round of awards. The Resource Allocation and Resource Inventory Committee intends to bring about the coordination of San Francisco prevention services funded by different sources -- so that prevention will be concentrated in those populations at highest risk, all populations will be

reached by at least some general HIV education and prevention activities, and there will be a range of services provided, without duplication.

Regarding the set-asides and bidding decisions, Jimmy reported that the committee was revisiting all of the issues involved with creating set-asides and making sole-sourcing or bidding decisions. Because it was still unclear how the committee's recommendations might change, Jimmy said that he was reluctant to present further information on this task at this time. Valerie added that the committee would report on this work again on May 9th.

Council Input:

- Liz asked about the availability of TA to providers, to help them arrive at valid risk scores for their populations. *Valerie explained that the Priority-Setting Training provided at intervals by the AIDS Office, along with the Bidders' Conference to take place after the RFP is released, would offer this kind of specific instruction. Jimmy underscored that the committee itself would not be able to provide TA.*

- Hank asked about the bidding decision criteria (whether these criteria had been written explicitly anywhere). *Jimmy noted that the criteria had undergone some revisions, and that the committee was still questioning its process around these decisions. Currently, a document is being drafted with program descriptions for each of the set-asides, and the reasoning behind each of the committee's previous decisions. He added that Council members with further questions on the committee process may call him, at 563-0553.*

12. EVALUATION

Christina Goette spoke for the Process Evaluation Team, which has been giving the Council ongoing summaries of members' feedback, in order to help the process respond and develop. The group of evaluators has been turning around the input received as quickly as possible.

Christina noted that every committee which had met in the past two weeks had agreed that it didn't want to experience what the Resource Allocation Committee had experienced immediately following its presentation at the last HPPC meeting. As a result of the general desire to prevent such surprises, the Steering Committee had since developed the concept vote procedure. Christina highlighted this procedural change as a positive and adaptive Council response to an unexpected challenge. She asked members to keep filling out the forms distributed (with the minutes or in separate packets or handouts) by the Process Evaluation Team, so that the Council can continue to learn about itself and to identify and respond to emerging needs.

13. MEMBERSHIP COMMITTEE

The membership committee has recommended some changes to the by-laws (which are underlined in the committee document submitted in the packet), to receive a Council vote in May.

14. CLOSURE AND ADJOURNMENT

The Council was dismissed at 6:00pm, after completing and exceeding the items on its agenda. Valerie thanked the members again for their hard work, ready participation, and continued commitment in the planning effort.

Enclosed with These Minutes (for those absent):

- Steering Committee minutes from 4/19/96
- Summary of previous Council decisions (starts with the heading "**PRIORITY SETTING**")
- Revised "Goals and Objectives for the 1996 HIV Prevention Planning Council (HPPC)"
- Draft "Recommendations on Resource Allocation for HIV Prevention"
- Membership Committee memo with guidelines, procedures, and bylaws for Council approval
- Evaluation Results and Participant Dialogue box feedback from the April 11th meeting

Enclosed for All Members:

- Letter from the Women's Positive Care Coalition
- Questions being addressed by the Evaluation and Technical Assistance Committee

Next Meetings:

- Thursday, May 9th, from 3-6pm at the First Unitarian Church (1187 Franklin @ Geary)
- Thursday, May 23rd, from 3-6pm at the First Unitarian Church (1187 Franklin @ Geary)

Minutes Recorded by: Mary Irvine
Minutes Approved by: Co-Chairs Valerie Kegebein and Ronnie Ashley (Chata)

HIV PREVENTION PLANNING COUNCIL MEETING

May 9, 1996
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

Please read: Agenda, minutes of April 25, Committee minutes, Reports from Membership, Goals & Objectives, and Resource Allocation/Resource Inventory Committee

Please bring: Entire package, applicable committee meeting minutes

Agenda

1.	Welcome & Introductions	Ana Claire Meyer	3:00-3:05 PM
2.	Minutes	Ana Claire Meyer	3:05-3:10 PM
3.	Announcements	Valerie Kegebein/Members	3:10-3:15 PM
4.	Public Comment	Valerie Kegebein	3:15-3:35 PM
5.	End of First Quarter Review	Kathleen Roe	3:35-3:50 PM
6.	♦*Membership - Vote on 3 items:* 1. By-Laws 2. Meeting Participation Guidelines 3. Public Comment	John Hamilton	3:50-4:05 PM
7.	Break		4:05-4:15 PM
8.	♦Goals & Objectives -Vote	Barbara Adler	4:15-4:25 PM
9.	♦Linkages - Vote	Chata	4:25-4:40 PM
10.	Evaluation/Technical Assistance - Update	Roberto Garcia	4:40-4:42 PM
11.	Epi/Research - Update	Patrick Forte	4:42-4:44 PM
12.	♦Resource Allocation/Resource Inventory - Vote	Jim Naritomi	4:44-5:55 PM
13.	Evaluation	Members	5:55-6:00 PM

NEXT MEETINGS:

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - May 23, 1996, 3:00-6:00 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary).

SF DPH

HIV PREVENTION PLANNING COUNCIL MINUTES

May 9, 1996

Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Isabel Auerbach
Hector Carrillo
Christine Edwards
Patrick Forte
Dale Frett
Roberto Garcia
Ellen Goldstein
Liz Highleyman
Valerie Kegebein
Sacul L'Adnbre
Marvin Lee
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Chandra Pugh
Bethsaida Ruiz
Terry Ryan
Zwazzi Sowö
Joshua Tager
Joshua Volle
Hank Wilson
Edward Zold

Guests:
Carol Badran, WEDGE Program
Steve Purser, DPH (Family Health)
Michael Ross, WEDGE Program

Members Absent:
Michael DeMayo
Fernando Gomez-Benitez
Natalie Gutierrez
John Hamilton
Chinyere Madawaki
Ramon Martinez
Dominic Perez
Jay Seward
Sandy Simms

AIDS Office:
Kristen Clements
Gene Copello
Lyn Fischer-Ponce
Delia Garcia
Tracey Packer
Mike Pendo
Billy Pick

Evaluation Team:
Cindy Berenstein
Christina Goette
Paul Lund
Valerie Paz Soldan
Kathleen Roe
Kevin Roe

Polaris, Inc./Harder + Co.:
Mary Irvine, Polaris, Inc.
Lyn Paleo, Harder + Co.
Eden Tanovitz, Harder + Co.

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1. WELCOME & INTRODUCTIONS

Ana Claire Meyer convened the meeting shortly after 3:00pm. Those present introduced themselves and gave their agency affiliations.

2. MINUTES OF 4/25/96

The minutes of the last meeting were approved without exception.

3. ANNOUNCEMENTS

- Valerie announced that the Selection Committee had chosen four people for appointment to the Council, and was currently waiting to receive their letters of acceptance. The committee succeeded in meeting its solicitations for representation from particular communities.

- Valerie notified members of an HPPC retreat tentatively planned for June 21st, from 9am-2pm (but she asked that people keep the whole day open, if possible). She described the retreat as a break from the usual HPPC business and an opportunity to get some perspective on the process.

- Valerie also announced a prospective update on the HPPC process of the past 2 and 1/2 years. She said that the informational session could be offered in a small group setting from about 1:30-3pm on Thursday, May 23rd (before the Council meeting that day). People interested in building their understanding of the work done previously in the Council are welcome to attend. Valerie suggested that those interested in the update should write their names on pieces of paper and turn them in to her, even if they could not make that time.

- Lyn Paleo announced a job opening at Harder + Co. for a new research assistant. She asked that people inform anyone they know who might be interested and qualified.

- Valerie asked guests to sign in on the "Guest Sign-in Sheet," and to include their agency name and address, if they wish to receive the Council minutes.

- Valerie referred to the LIFE Institute handout distributed at this meeting. She explained that the letter had been given to her for circulation to Council members, and that it is a solicitation of potential contributors to the Technical Assistance Consultant Pool being developed by the LIFE Institute. (The letter and application are enclosed for those absent.)

- Liz Highleyman announced an upcoming meeting of the Sex Worker Advocacy Network, which is a fairly new group. She encouraged outreach workers who are familiar with sex workers' communities to attend the meeting on Friday, June 7th, from 12-2pm at the SEIU offices, at Market and 9th streets. Those interested should contact Liz Highleyman.

4. PUBLIC COMMENT

Valerie gave a quick review of the procedure for public comment.

Carol Badran of the WEDGE Program read a statement by Ari Toomey, a WEDGE volunteer speaker who was unable to attend this meeting. Ari's statement in support of the WEDGE is enclosed with these minutes.

Michael Ross of the WEDGE Program also spoke on the need for a set-aside of funding for this school-based program. He explained that Ari's story is not atypical, and that she represents the growing population of young women who are infected or at risk for infection but do not fit the behavioral categories established by the HPPC Priority-Setting Subcommittee. He asked the Council to consider a set-aside sufficient for the WEDGE Program to reach mainstream middle-school and high-school youth, in addition to the youth that have been identified as highest-risk.

HPPC Responses to Public Comment

Sacul agreed with the speakers that the WEDGE reaches a large number of people, and that there is a serious need for prevention services targeting youth who are in denial about their risk for HIV. Marvin also expressed his support for the WEDGE. He stated that the WEDGE is necessary as an educational adjunct and that the program connects faces to the endemic amoung youth.

5. END OF FIRST QUARTER REVIEW

Dr. Kathleen Roe began her address to the Council by noting that the HPPC is now one-quarter of the way through its work for Year III. She explained that the Evaluation Team will be giving the Council quarterly summaries of the process evaluation results. Referring to the handout, "Evaluation Results: Participant Evaluation of 4/25/96 HPPC Meeting," she went over the responses aloud and remarked on significant trends.

Kathleen noted that, according to the meeting evaluations completed by participants, the early HPPC meetings had met all of their objectives and indicated the emergence of an effective group process. Although the Council had not met its objectives two meetings ago (on April 11th), the scores for meeting objectives had risen at the April 25th meeting. She felt that the Council had "righted itself," after the difficult April 11th meeting.

In the "Logistics" section, Kathleen pointed out that about one-half of the members were having trouble reading all of the HPPC-related materials they receive. She also noted that a significant number of members were unable to retrieve faxes on a daily basis, and might not be able to read some of the Council materials sent immediately prior to meetings. She observed a chronic problem in the necessity that some committees meet and produce important materials for Council decision-making just a few days before the Council meetings. This situation leads to some rushed faxing on committee work, which puts stress on members trying to prepare for meetings in a short period of time.

Kathleen called the attention of members to the finding that about 25% of the Council cannot attend meetings before 3pm on Thursdays. She said that this finding explains why many members have been arriving at 4pm, even when they have received notices about the extended (3-6pm) meeting time. She suggested that the Council might want to consider an alternative to this earlier time, in order to gain full participation.

Next, Kathleen pointed out the section of questions and responses on how much of the Plan members have read. She suggested that members who have not been able to read much of the Plan focus on those sections that seem to have the most relevance to their individual committees. In some of the committee updates and summaries, there are references made to the particular pages in the Plan that relate to committee recommendations. These should help members to prioritize areas of the Plan for their reading.

Talking about the group dynamics of the Council over time, Kathleen related the Council process to the three basic stages in a group dynamics cycle: (1) forming (the honeymoon period), (2) storming, and (3) norming and performing. She noted that the Council dialogue boxes had generally yielded warm, appreciative, and friendly comments about planning process participants. Members have continued to be courteous, sensitive, and respectful toward each other. Kathleen thought that the Council had had its first experience of "storming" at the April 11th meeting. However, she remarked on the way in which the Council had managed to "find its own compass" and get back on track by the next meeting. There was a generally favorable response among members to the institution of the "concept vote," which was designed to keep Council members better informed of the work of other committees, to prepare members for the decisionmaking they are expected to do as a full Council, and to give committees early feedback on their approaches to committee tasks. Kathleen expressed her sense that the HPPC was better able to transition quickly from "storming" to "norming/performing" than most groups.

Kathleen noted that newer members were responding at a greater rate (75-90% each week) to the evaluation forms than were the veteran members. She was concerned that longer-term members may be experiencing some burn-out on the process.

Nearing the end of her presentation, Kathleen mentioned some areas in which the San Francisco HPPC has distinguished itself:

- who the members are (in terms of their background, experience, and commitment);
- the level of experience of the AIDS Office staff who are working with the Council;
- the diligence and expertise of the consultants;
- the incorporation of the in-process evaluation (and the immediate usefulness of this information); and
- the overall sensitivity of the group (on the use of language, on issues of timing and pace, and on issues of how the members interact with one another).

In closing, Kathleen mentioned some challenges that the Council would be likely to encounter in the coming months. She said that the Council would have to consider the constraints of time and of cost, for the amount and quality of work it expects to accomplish this year. She also stressed the need to examine, at this stage in the process, the extent to which different members are or aren't included in discussions and decision-making. The last note that Kathleen made about upcoming issues for the Council was that it will be important to keep Council members at the heart of the committees, rather than allowing the bulk of committee work to be performed by AIDS Office staff, consultants, and/or non-Council committee members.

Question and Answer
Following the Evaluation presentation, Ellen questioned Kathleen's description of the disagreement expressed at the April 11th meeting as a moment of "derailment" for the Council. Ellen saw the disagreement and ensuing discussion as a necessary and productive development in the Council process. In response, Kathleen agreed with Ellen's point, and said that she had been referring to a straying away from the meeting objectives, which were not fulfilled on April 11th.

6. MEMBERSHIP -- *Vote on Three Items*
The Membership Committee presentation and voting was postponed for the arrival of Committee Chair John Hamilton. Since John was unable to make it to any part of this meeting, the presentation had to be postponed until the next Council meeting.

7. GOALS AND OBJECTIVES -- *Vote*
Chair Barbara Adler explained the changes that the committee had made, in response to Council input, to the recommended prevention goals for the 1996 RFP. The first goal was edited down to #1(a) and (b), and the wording of (b) was altered slightly, to take into consideration the stages leading up to behavior change. For Goals #2, #3, and #4, the sentence structure and wording were changed in order to more clearly communicate the focus of each goal. Goal #5 was revised to clarify the role of the AIDS Office in establishing a diversity of strategies and interventions.

Discussion
Jimmy requested that committees submitting more than one version of a committee document to the Council include a revision date on each version, so that Council members know what materials they can discard. There was no apparent disagreement with this suggestion.

Ellen said that she was still not sure how knowledge, attitudes, and beliefs were being incorporated in Goal #1 (as she had requested at the last Council meeting). She expressed her concern that interventions which affect knowledge might be dismissed, because of the focus on behavior change.

Barbara responded that the committee had seen behavior change as the larger goal of any prevention effort. Committee members had agreed that the wording of the goal should not exclude the possibility of interventions which target knowledge, attitudes, or beliefs. However, they did not want to make these intermediate stages of change the drive or the focus of the goal. The committee had agreed that changes in knowledge, attitudes, and beliefs participate in the larger movement toward behavior change. Tracey added that the committee had not wanted to suggest that strategies and interventions have the option to focus on knowledge alone, for example. Each provider must assess the stage of change appropriate for the target population, and meet the population with interventions targeting that stage. While the population may at first only be receptive at the level of knowledge development, the provider should view this development as a step leading toward behavior modification. In support of the committee's choice, Valerie explained that the RFP prevention goals represent the longer-term perspective, while the outcomes for programs will be touching on the intermediate steps.

The Consensus
The Council voted unanimously to accept the recommended Prevention Goals for the 1996 RFP.

8. BREAK

9. LINKAGES -- *Vote*
Chair Chata (Ronnie Ashley) explained that the Linkages Committee had taken the recommendations of the Council for inclusion of language around mediation mechanisms and for a breakdown of what is meant by "autonomy" in collaborations. In the fax ("Linkages Committee Report to the HPPC -- May 9, 1996"), all recent changes and additions are underlined, while omissions are shown with lines striking through the center of the deleted phrases. The added introductory section to the document expresses the committee's larger vision of collaboration (including the idea of self-governance/autonomy of partners). Issues of non-compliance and mediation mechanisms are addressed at various points in the document (e.g., the first quoted and underlined definition, and recommendations #3, #7, #8, #9, and #11).

Discussion
Joshua described the committee document as "wonderful" in its clarity and comprehensiveness.

The Consensus
The Council voted unanimously to accept the recommended Required Elements of Proposed Collaborations.

10. EVALUATION AND TECHNICAL ASSISTANCE -- *Update*
Chair Roberto Garcia explained that there had not been a quorum present at the last committee meeting, so that members would need to meet again to discuss decisions to be brought before the Council. The minimum required variables for data collection (as recommended by the committee at its next meeting) will receive a vote at the May 23rd HPPC meeting. The committee update sent by the AIDS Office to Council members (and dated 5/3/96) summarizes other developments in the committee process around data collection requirements and the OD/TA project.

11. EPIDEMIOLOGY AND RESEARCH -- *Update*

Chair Patrick Forte said that the committee had identified a set of underresearched San Francisco populations and had set priorities within the broader set, to produce the bulleted list of five populations that appears in the committee update. After setting its priorities (based on availability of local data on each population and some committee discussion of probable HIV risk), the committee began to lay out the steps for organization of key informant group interviews. Each panel will focus on a particular underresearched population, and will be asked to respond to the committee's interview questions. The committee hopes to use the key informant interviews to begin filling in some of the most glaring gaps in the existing epidemiological chapter. The first sessions have been scheduled for May 20th, May30th, and June 17th.

Discussion

A member asked what the committee meant by "formative data" (mentioned in the committee update distributed previously by the AIDS Office). Lyn Paleo responded that the committee had reviewed the epidemiological chapter and a list of newer San Francisco studies from which data will be ready for inclusion in the Plan. Members discussed the availability of prevalence and/or behavioral studies for populations that they had listed in a brainstorming session on possible groups for future research. Then they set the priorities for the key informant interviews, to be conducted with people who have experience with the prevention needs of the chosen populations. The qualitative information yielded by these interviews can be added to the epidemiological chapter in the Plan, and may assist in the formation of future research projects.

Liz mentioned that this might be a good opportunity for the committee to ask Council members about possible contacts for the panels. Lyn said that the committee now has some contacts for each of the priority populations, but that names that Council members could offer would also be welcome (she asked that written suggestions be submitted to her). AIDS Office staff are also suggesting potential interview contacts to the committee.

Jimmy asked whether "Immigrants" would be broken down into more specific groups for the committee interviews. He wondered how effectively a panel on *all* immigrants would serve the purpose of qualitative data collection. Patrick responded that the committee had not yet refined all of the priority populations, but was working on it. (For example, migrant workers will be one focus area for the immigrant populations panel.)

12. RESOURCE ALLOCATION AND RESOURCE INVENTORY -- *Vote*

Valerie noted that a newer version of the "Set Aside Activity Description" document, dated 5/8/96, was going around the table at this meeting (enclosed for those absent), and that changes made to the numbers were indicated by a strike-through. Members present added the new document to their Resource Allocation and Resource Inventory (RA/RI) materials, and discarded the older version.

Chair Jimmy Naritomi asked RA/RI members and consultants to stand and be recognized. He then talked about the frequency of RA/RI committee meetings and the meticulousness of the committee process. As it worked toward the completion of its first tasks, the committee engaged in earnest discussions around process questions and internal disagreement.

Recent Changes to the Resource Allocation Process

Jimmy reminded the Council that, at the last HPPC meeting, he had presented the first few pages of the document titled "Recommendations on Resource Allocation for HIV Prevention," up to the

section about the role of set-asides (on p. 4). He noted the changes that the committee had since made to the "Current Year's Proposed Resource Allocation Process":

- The criteria for validity of provider-supplied data will not be specified in #4, but will be determined by an independent review panel.
- A criteria on collaboration will be added to #5f, in accordance with the Linkages Committee presentation and vote from earlier in this meeting.
- Three principles for proposal selection were added to #6.
- The wording of #6 was revised to emphasize that the populations at greatest risk for HIV (those with the highest behavioral frequency/prevalence scores) will receive the first consideration for prevention funding.
- Also in #6, the committee noted that the AIDS Office may specify the minimum number of proposals to be funded with the total available for the first RFP. Members had suggested the idea of the minimum number as a way of helping providers to set realistic expectations for the amount of funding available for a given proposal. They hoped to encourage providers to request appropriate amounts of funding -- given the total amount available, the need for a range of services, and the overall prevention priorities.

Resource Allocation Policy Decisions

Jimmy explained that, following the April 11th HPPC meeting, a subgroup of the committee members and consultants had met with AIDS Office staff to clarify some of the policy issues around resource allocation. In view of the reluctance of the Council to make program-specific or "dollars and cents" decisions, and in order to move along the necessary decision-making process, the meeting participants developed suggestions for a revised approach to resource allocation:

1.) The Council is asked to vote on whether to set aside funds for the *block* of activities previously recommended by the committee. This allows for one large vote, to be accompanied (as needed) by separate votes on amendments to remove any of the individual activities from the block of set-asides.

2.) The Council is relieved of the responsibility for decision-making on sole-sources for the set-aside funding. Members will still have an opportunity to offer input on which set-aside activities should or should not be put out to bid, and the discussion will be recorded and submitted to the AIDS Office, for use in the AIDS Office process of determining sole-sources among the set-asides. While the recommendations of Council members will be noted in detail and considered seriously by the AIDS Office, no vote will be taken on the bidding of set-aside activities.

3.) The Council is relieved of the responsibility for decision-making on whether to increase, decrease, or maintain funding levels for the set-aside activities. Members will still have an opportunity to give input on these issues, during a full Council discussion to be recorded and submitted to the AIDS Office, for use in the AIDS Office process of determining funding levels. While the recommendations of Council members will be noted in detail and considered seriously by the AIDS Office, no vote will be taken on the funding levels for set-aside activities.

Valerie pointed out that a number of the tasks originally assigned to the committees were found, upon later examination, to be beyond the purview of the committee or the Council. Council and/or committee members had acknowledged conflicts of interest around the minimum score for proposal consideration, the criteria for validity of data, the bidding/sole-sourcing decisions, and the decisions on funding levels for set-aside activities. As a result of the conflicts of interest and lack of

sufficient information noted by Council members, the HPPC will no longer be charged with making the most specific resource allocation decisions, but members will be encouraged to look at the information furnished by the committee and to give input to the AIDS Office. This input will be taken at the May 23rd HPPC meeting, and may also be submitted in writing.

Discussion (of policy issues and the "Current Year's Proposed Resource Allocation Process")
Hank asserted that much of the language of existing committee documents would need to be revised, to reflect the policy issues outlined above.

Bethsaida asked about the independent data review panel mentioned on p. 3, #4. Jimmy explained that this item refers to the provider-supplied data supporting higher-than-average risk scores for particular target populations (the overall score for the behavioral group represents an *average* for populations within that group). Jimmy said that an extremely knowledgeable and specialized subcommittee (also screened for conflict of interest) would be required, to look at the criteria for data validity. Lyn Paleo has begun to contact potential members of this subcommittee.

Hank asked if the Council would be informed of the amount of funding to be allocated for each behavioral category. Valerie answered that this information would remain unknown (to anyone) until after the proposals were received. Ana Claire added that, for now, the AIDS Office and Council can only be informed of the principles for proposal selection and the system for scoring proposals (using the committee's criteria).

Terry asked if the AIDS Office would be rating the uniqueness of proposals. She also asked about the principle on preventing duplication of services; in her understanding, the duplication of services was sometimes necessary. Valerie responded in the affirmative to Terry's first question. Regarding the intention to avoid duplication of services, Valerie explained that different interventions to the same target population could still be funded simultaneously (if they are complementary services). The committee simply wanted to recommend against, for example, funding different proposals for the same service to the same population in the same neighborhood.

<u>The Consensus</u>
Of the 22 voting members present at this point in the meeting, *20 voted in favor* of the motion to approve the "Current Year's Proposed Resource Allocation Process" (pp. 3-4), and *2 abstained.* The motion carried.

The Role of Set-Asides in Resource Allocation
Jimmy explained the procedure for voting on set-asides (an attachment on this procedure is enclosed for those absent). The procedure would begin with a motion to accept the block of set-asides recommended by the committee. Then members would be able to create amendments to remove particular prevention activities from the set-aside block. Each amendment would require a motion and a second, which would then lead to a vote on whether to discuss the amendment (for four minutes -- two minutes of comments in favor of the amendment, and two minutes of opposing comments -- and possibly for another four minutes, if requested and approved by the Council). Following the discussion or the vote not to discuss the amendment, a Council vote would be taken on whether to accept the amendment proposed. After each proposed amendment had received a vote, the Council would vote again on the block of set-asides, *with the approved amendments.*

Hank spoke up to say that the four minutes of discussion time on each proposed amendment seemed inadequate to him. He wanted everyone to have a chance to make his/her case, and didn't

want to see a "railroading" of the process. Ana Claire stated that members would be able to vote to take more time for a particular discussion, and would always be able to ask clarifying questions before each vote.

Jimmy summarized the recent changes made to the "Role of Set-Asides in Resource Allocation" document:

Additions

- sentence (p. 4) -- "The decision of sole-sourcing will be made by the AO, based on input from the Council."
- sentence (p. 5) -- "All prevention activities funded through the set-asides will be held to the same standards as those responding to the general RFPs."
- compilation, from the minutes, of set-aside stipulations raised in the committee
- descriptions, as requested by Council members, of each prevention activity for which a set-aside is recommended (revised 5/8/96)

Deletions

- two bulleted items under the criteria for set-asides (previously, the third and fourth criteria referred specifically to sole-sourcing considerations)
- the "Put Out to Bid" column of committee recommendations, in the chart on set-asides

Discussion

Joshua said that he felt the committee had put together a good document, but that he was still philosophically against the idea of set-asides (which he thought would contradict decisions made in the first two years of the planning process). He appreciated the information on legal issues for certain prevention activities, and added that only for those cases with special legal circumstances would a set-aside be justified. In his view, if the set-asides were recommended as a way to fill in the gaps left by the priority-setting process, then the Council should take a closer look at why its priority-setting process failed to account for those areas. Joshua's second point was that the Council should not be asked to vote on the block of set-asides, after having made its opposition to this approach explicit at the April 11th meeting.

Ellen asked roughly what percentage of last year's funding the block of set-asides would represent. She noted that the general education category was new, and wondered overall what portion of the total funding for prevention was likely to go into the set-asides. She saw this issue of funding proportions as relevant to the philosophical basis for set-asides (in that the exceptions to the priority-setting process should not take up a large percentage of the total prevention funding). The co-chairs responded that the set-asides currently use between three and four million dollars, or a little under 40% of the total prevention funding (which is about 10.6 million). This estimate excludes the cost of administration.

Ellen also said that, while she appreciated the removal of sole-sourcing decisions from the HPPC tasks, she did not want members to be fooled by the notion that they are simply voting on set-asides. In her understanding, the vote on set-asides would also be making a strong implicit recommendation for particular agencies to receive the funding.

Isabel wondered about how the set-asides would tap into the different sources of prevention funding (CDC, State, and General funds). Valerie explained that no decisions had been made yet about which set-asides would come out of which pots of funding. Jimmy added that the issue is

partly one of the continuity of services (which depends on the current funding source(s), the schedule on which the AIDS Office receives its different funding types, and the choice of funding sources from which to draw for the next set-asides).

Terry asked if the CDC had given the AIDS Office any indication about what it can and will fund. Ana Claire responded that the CDC guidelines that used to apply to the AIDS Office no longer apply. Instead, the CDC has asked local health jurisdictions to exercise authority over their local prevention services. Joshua added that the CDC wants local planning groups to define their needs and the best interventions to meet those needs. Each DPH will distribute the funding to its area. Ana Claire noted that, should this local jurisdiction do something completely out of line with the CDC guidance, then the CDC could still choose not to fund the AIDS Office.

Terry asked about the relation between the prevention activity descriptions document and the set-aside stipulations. Jimmy explained that the Council had requested the activity descriptions, as supplementary material for the voting process on continuance of set-asides. The stipulations, on the other hand, were pulled from the many sets of committee minutes. They had been stated by members as the conditions for continuance of funding for particular set-asides. Lyn added that the stipulations represent particular expectations of particular prevention activities, beyond the requirements stated in the Plan. The stipulations do not directly relate to the descriptions, and may be augmented by suggestions from the Council. The descriptions simply offer background details on the activities, as they have been conducted up to this point.

Ellen said that she understood the descriptions to be *program* descriptions with the agency names removed. Ana Claire acknowledged this point, but noted that some of the activities have been conducted by more than one agency.

Mark voiced his sense that he would have a conflict of interest around voting on the proposed set-aside for City Clinic. He wondered if he should abstain from voting on this particular program. Lyn responded that she thought a conflict of interest would arise only if the agency could receive material gain from the decision made. She stated that it was still unclear whether the decision in favor of a set-aside would lead to a greater material gain than would the general RFP process.

Liz asked whether federal funds could actually be used for needle exchange. Valerie replied that *non-syringe* supplies for needle exchange could be purchased with federal funds.

Hank asserted that there are gaps in the priority-setting process that apply for certain populations (such as youth), but that those gaps could be remedied by the AIDS Office even without the use of set-aside funding. He stressed the role of the stipulations for regulating set-aside activities, and encouraged members to recommend additional stipulations. In concept, he supports the set-asides.

Regarding the potential conflicts of interest for members whose programs correspond to the set-asides, Barbara said that it was still unclear which agency would be chosen to provide a given set-aside intervention, or even how the choice would be determined.

Hector asked if the Council could be informed of the total amount of funding available for the spring RFP. Valerie said that the amount of the General fund was unknown at this stage, but would likely come to about three million, and the State would contribute about 1.6 million -- so the total should reach about 4.6 million for the spring RFP. Ana Claire reminded members that the

funding sources for the set-asides have yet to be decided. Terry asked if there would be any "match money" involved, and Valerie answered that it would not.

The Amendment Process
Because of the feedback from the Council on the idea of the block vote, the co-chairs agreed to begin the voting procedure by calling out each set-aside and checking to see if anyone would want to withdraw it from the set-aside activities. The first vote on the committee-recommended block, then, was cut out of the process.

There was just one proposed amendment to the set-asides, for the withdrawal of the city-wide collaboration on street outreach. Ellen said that she would not want a set-aside for the street outreach collaboration, because **(1)** many agencies conduct targeted street outreach on their own (and should be able to propose street outreach as a component of their individual programs), **(2)** the goals of street outreach are still inconsistent and controversial, and **(3)** she was not convinced that street outreach is effective in bringing about behavior change.

Clarification
Valerie explained that the street outreach collaboration would not preclude other agencies from doing *recruitment* into their own programs. Many programs have referred to their recruitment activities as street outreach, but the street outreach collaboration would only bar outside programs from receiving funding to offer on-the-street prevention services.

The motion to withdraw the street outreach collaboration from the block of set-asides was seconded, and a majority voted to discuss the amendment (7 were in favor, two were opposed, and the rest abstained in this vote).

Discussion (of the amendment to withdraw street outreach collaboration from the set-asides)
Clarification
Isabel asked what it means to prohibit outreach, but not recruitment, by individual agencies. Valerie responded that participant recruitment by individual agencies would still be an accepted activity. However, street outreach including prevention information, distribution of prevention materials, and/or referral services would not be performed independently of the collaboration.

Pros (in favor of the amendment to withdraw street outreach collaboration from the set-asides)
- Liz said that she was in favor of withdrawing the activity, because individual agencies who can do outreach to their target populations and can justify their activities should not be prevented from offering this type of service.
- Zwazzi said that she was familiar with an agency in Bayview/Hunter's Point that was providing city-wide street outreach, and that she was not impressed with its methods. She described this agency as territorial and unwilling to work at all with other programs. The result, as she saw it, was a lack of coordination bordering on chaos.
- Hector asked members to maintain the public health perspective, which looks at how services will effect progress toward behavioral change. He said that he supported street outreach as a means of helping clients along in their movement toward behavior change. He was in favor of keeping up some competition between agencies that would propose to do street outreach.

Cons (opposed to the amendment to withdraw street outreach collaboration from the set-asides)

- Joshua said that, despite the confusion around the efficacy of street outreach, there is a general agreement about the purpose of street outreach. He argued that the collaboration increases efficacy, by orchestrating the intervention on a city-wide level. Before the establishment of the collaboration in San Francisco, there were numerous problems with gaps and with duplication of street outreach services.
- Valerie expressed her conviction that there should be a coordinated effort to reach people at risk where they are and with consistent prevention approaches.

Following these arguments, the Council engaged in a brief discussion. Liz said that she still doesn't see why other agencies should be prohibited from doing street outreach. Valerie replied that it is partly an issue of semantics; for an activity to be called street outreach, it has to fulfill certain requirements now, and to provide certain components to clients in a standardized way. Liz stated that she had been referring to the actual street outreach (which she thought agencies should be able to do independently), and not just the recruitment. Zwazzi asked for clarification on whether the set-aside would reserve funding for the current provider of the collaboration, or just for the idea of the collaboration. Ana Claire explained that the set-aside was for the collaboration, and not for the current provider. Hector pointed out that the AIDS Office could, however, decide to sole-source the contract to the current provider. Ana Claire responded that Council members could strongly recommend that the AIDS Office put the street outreach collaboration out to bid.

The Vote (on whether to withdraw the street outreach collaboration from the set-asides)
In Favor: **10**
Opposed: **7**
Abstentions: **4**
The amendment to strike the collaboration from the block of recommended set-asides carried.

The Vote (on "The Role of Set-Asides in Resource Allocation," with the above amendment)
In Favor: **17**
Opposed: **2**
Abstentions: **3**
The motion to accept the revised and amended committee document on set-asides carried.

13. ADJOURNMENT
With the completion of the committee votes, the co-chairs adjourned the meeting. Ana Claire asked members to review the stipulations for set-asides and bring back their input and additions.

Enclosed with These Minutes (for all members):

- ♦ Harder + Co. job announcement
- ♦ Statement from Ari Toomey, speaker for the WEDGE Program

Enclosed with These Minutes (for those absent):

- ♦ Letter and application from the LIFE Institute, for the Technical Assistance Consultant Pool
- ♦ Evaluation Results from 4/25/96
- ♦ Participant Dialogue responses from 4/25/96
- ♦ Agenda for RA/RI presentation, and write-up of the procedure for voting on set-asides
- ♦ Newer version of the "Set Aside Activity Description" document, dated 5/8/96

Next Meeting: May 23rd, from 3-6pm at the First Unitarian Church -- 1187 Franklin St. @ Geary

Minutes Recorded by: Mary Irvine
Minutes Approved by: Co-Chairs Valerie Kegebein and Chata (Ronnie Ashley)

HIV PREVENTION PLANNING COUNCIL MEETING

May 23, 1996
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

SF
H 12
2
5/23/96

Meeting called by: Co-Chairs:
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

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Please read: Agenda, minutes of May 9, Committee minutes, **Reports from Evaluation/TA, Membership and Resource Allocation/Resource Inventory Committees**

Please bring: Entire package, applicable committee meeting minutes, Membership Committee reports, Set aside Description(s)

Agenda

1.	Welcome & Introductions	Chata	3:00-3:10 PM
2.	Minutes	Chata	3:10-3:15 PM
3.	Announcements	Valerie Kegebein/Members	3:15-3:20 PM
4.	Public Comment	Ana Claire Meyer	3:20-3:40 PM
5.	***Presentation:*** HIV NET - Testing the Efficacy of Prevention Interventions	Susan Buchbinder	3:40-4:00 PM
6.	Break		4:00-4:10 PM
7.	→Membership – *Vote on 3 items* *1. By-Laws* *2. Meeting Participation Guidelines* *3. Public Comment*	John Hamilton	4:10-4:45 PM
8.	→Evaluation/TA - Risk Assessment Requirements Vote	Roberto Garcia/Ellen Goldstein	4:45-5:20 PM
9.	Resource Allocation/Resource Inventory •*Gathering Input on Set Asides*	Jimmy Naritomi	5:20-5:55 PM
10.	Evaluation	Members	5:55-6:00 PM

NEXT MEETINGS:

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - **June 13, 1996, 3-6 or 4-7 PM** (to be discussed), The First Unitarian Church, 1187 Franklin Street (@ Geary).

SF Public Health

HIV PREVENTION PLANNING COUNCIL MINUTES
May 23, 1996

Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Isabel Auerbach
Christine Edwards
Roberto Garcia
Fernando Gomez-Benitez
Natalie Gutierrez
Tony Hall
John Hamilton
Valerie Kegebein
Marvin Lee
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Chandra Pugh
Bethsaida Ruiz
Terry Ryan
Sandy Simms
Zwazzi Sowö
Joshua Tager
Joshua Volle
Gregory Walker
Hank Wilson

Guests:
Nick Farrel
Clara Gruen
Bruce Occena
Tomas Rodriguez
Luis Salinas
Jean Simmons (sp.?)
Wendy Wolf

Members Absent:
Hector Carrillo
Patrick Forte
Dale Frett
Ellen Goldstein
Liz Highleyman
Piper Hyland
Pamela Isaacs
Sacul L'Adnbre
Ramon Martinez
Dominic Perez
Jay Seward

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AIDS Office Staff:
Susan Buchbinder
Kristen Clements
Brian Dobrow
Marshia Herring
Paul O'Malley
Tracey Packer
Mike Pendo
Billy Pick

Evaluation Team:
Cindy Berenstein
Paul Lund
Kevin Roe

Polaris, Inc./Harder + Co.:
Mary Irvine, Polaris
Lyn Paleo, Harder + Co.
Eden Tanovitz, Harder + Co.

I. WELCOME & INTRODUCTIONS
The co-chairs convened the meeting shortly after 3:00pm. Those present introduced themselves.

II. MINUTES OF 5/9/96
The minutes of May 9th were approved with two exceptions, pointed out by Jimmy Naritomi:

1) The procedure for voting on set-asides (see **"The Role of Set-Asides in Resource Allocation"** -- p. 8) was largely presented to the Council by Ana Claire (not Jimmy).
2) The RFP including State and General funds and totaling at about 4.6 million will go out in the fall, not in the spring; the spring RFP will include only CDC funds.

III. ANNOUNCEMENTS

Valerie:

- There was a miscommunication at the last meeting, regarding the absence of John Hamilton. John had already informed the AIDS Office that he would be in Europe on May 9th.
- The AIDS Office frequently receives calls from members explaining that they will not be able to attend a particular Council meeting. The minutes will document which absent members have called ahead to notify the Council of their absence. For this meeting, both Patrick Forte and Ellen Goldstein called to say that they would not be able to come.
- Despite some rumors to the contrary, there **will be** a July HPPC meeting (on the second Thursday of the month).
- The Presidential Advisory Council on HIV and AIDS planned a public issues briefing for May 24th. All Council members were faxed the invitation with details.
- A few changes were made to the agenda for this meeting:
  - The Evaluation and TA Committee report was moved to follow the break.
  - An announcement from Kevin Roe was added to the agenda.

Ana Claire:

- Ana Claire brought a letter (enclosed for those absent) soliciting financial contributions for an HIV-positive single mother/grandmother from Hawai'i to attend the International Conference on HIV/AIDS in Vancouver this summer.
- The Steering Committee met last Thursday. First, members participated in a 90-minute facilitation training. Then they had about an hour-long discussion, regarding:
  - the procedure for Resource Allocation decision-making;
  - the agenda for May 23rd;
  - the biographical sketches on new members;
  - issues for the recruitment and screening of new members; and
  - concerns about the quarterly membership fill-in process.

  (Notes on the last two items will be submitted as input to the Membership Committee.)

Jimmy Naritomi:

- The Asian Pacific AIDS Coalition will be dissolved on June 30th, 1996.

IV. PUBLIC COMMENT

No public comments were offered at this meeting.

V. EVALUATION TEAM UPDATE

Kevin Roe offered the following information on the process evaluation of the HPPC:

- At the time of this meeting, 11 phone interviews had been conducted with current Council members. There is still time to make an appointment to complete one of these interviews.
- In response to the results of the evaluation question on committee participation, the Steering and Membership Committees are working on strategies for overcoming the barriers to participation in committees.
- The Evaluation Team received some criticism that the comments shown on the evaluation and participant dialogue results appeared to have been edited to sound "nicer" than their original versions. In response to this charge, the evaluators read through the old evaluation forms submitted by Council members, and checked for any discrepancies between the original comments and the results shown to the Council. The findings indicated that comments were taken verbatim from the forms completed by members. However, the

Evaluation Team has made it a policy not to print the personal comments that are directed at particular planning process participants, including the evaluators, as these comments lend nothing to the evaluation. The evaluators have agreed that it would be inappropriate to print such comments in any form.

- Members at this meeting were given a handout to complete, on whether they would be better able to attend meetings from 3-6pm or from 4-7pm (when three-hour meetings are necessary), and on whether they would want to attend the special orientation to the HPPC. (Lyn noted that this announcement should be repeated after 4pm, for those just arriving.)
- Participant dialogue boxes from HPPC members can be mailed or faxed to Kevin or Kathleen Roe, whenever these forms cannot be completed at the Council meeting. Please see the membership list (sent out by the AIDS Office) for the correct addresses and fax numbers.

VI. HIVNET PRESENTATION (Dr. Susan Buchbinder, with the AIDS Office Research Branch) Dr. Buchbinder explained that HIVNET refers to a group of research projects looking into the efficacy and feasibility of different prevention strategies. She said that the HIVNET staff want to engage in a dialogue with the HPPC, so that HIVNET research priorities address HPPC prevention priorities. The HIVNET studies, set up by the the National Institutes of Health, are intended to test vaccines, once this becomes possible. In the meantime, the studies are testing prevention strategies in multiple locations and with multiple populations around the world. (For details, please see the overhead copies, enclosed for those absent.)

Speaking about the domestic project sites, Susan said that HIVNET had been funded to look only at the MSM population in San Francisco, Denver, and Seattle. Among MSMs, there seems to be a higher rate of drug use in San Francisco than in the other cities.

Susan explained that the current vaccine preparedness study follows from an earlier feasibility study conducted with MSMs (who reported any anal sex in the past year) at three U.S. sites. The earlier study found in its sample a 2.6% infection rate per year. As the researchers looked at independent predictors for HIV seroconversion among these MSMs, they learned that:

1) condom failure rates were high (1 in 5 men reported experiencing condom failure in the last 6 months);
2) young men (defined as 18-25 years of age, since this study could only recruit respondents ages 18 and over) were especially at risk for seroconversion; and
3) men with a previous history of STDs were especially at risk for seroconversion.

While the researchers who conducted this study had wanted to investigate the risk of unprotected fellatio, they found that it was difficult to recruit men who had not engaged in any unprotected sexual activities other than fellatio (this group seemed to represent a relatively small percentage of the population of MSMs).

The Early HIV Infection Study has been looking at:

- the risk factors among injection drug users, men having sex with men, and women having sex with men;
- the development of any symptoms at the time of seroconversion;
- the early natural history of the body after seroconversion; and
- the mechanisms for referral of clients who seroconvert.

Regarding the Home Specimen Collection Study, Susan said that researchers are hoping to identify new infections as soon as possible, in order to chart the changes occurring in the immune system,

and to test the theory that very early treatment can heavily suppress viral replication, or even clear the virus from the host (retroactively preventing infection -- in the manner of a "morning-after pill").

Giving background on the rectal microbicide studies, Susan explained that there has been a dearth of information about whether non-oxynol 9 works to prevent HIV, and whether it is safe when used rectally. She added that the applicators, designed for vaginal insertion, do not translate well to rectal use. The study is working along with manufacturers, to develop applicators that will be functional and comfortable for both vaginal and rectal use. The sample consists of a group of monogamous couples, each of which has two people with the same serostatus (both positive or both negative). As the study progresses, the researchers expect to learn about the safety or toxicity of microbicides and their effects on transmission.

Susan said that there is still a great deal of work to be done, before vaccines can be taken into the field. The HIVNET project needs to establish informed consent and to understand the motivators and barriers for participation in trials (so as to gain as broad a sample as possible). The project hopes to begin testing vaccines early in 1997. Susan added that she would like to return to speak to the HPPC, when it appears that the vaccine trials will be going forward.

Discussion

Gregory asked about the planned process of recruitment for vaccine trials in Sub-Saharan Africa. He was specifically concerned about the process of gaining informed consent, and the ethical issues involved. Susan responded that each site has a community advisory board (consisting of potential study participants, members of local boards of health, and health providers). The project aims to involve the entire population of an area targeted, for each of the studies being conducted. Susan listed the topics of studies already begun for populations outside of the U.S.:

- vaginal microbicides;
- behavioral interventions with factory workers; and
- prevention of perinatal transmission.

Ana Claire asked about the presence and proportions of WSW or WSW&M subjects in the HIVNET studies. Susan said that there are WSW and WSW&M participating in the research, but in a relatively low proportion. She estimated that less than 5% of the subjects are women who have sex with women. However, she noted that women in general are underrepresented in the HIVNET research. There has been an effort to convince the funders to set up sites recruiting more women. Ana Claire also asked whether sites had been considered for Asia, and Susan replied that there are already sites established in Thailand and India.

Tony asked whether the HIVNET offers psycho-social services for newly-infected participants. Susan responded that one-on-one counseling is made available to participants, and that the project has facilitated the formation of support networks by and among the participants. According to the needs of the participants, the project also refers them to local organizations. Tony wondered whether the studies were measuring the differences in behavioral risks, for those receiving or not receiving psycho-social support. Susan agreed that this is an important difference to investigate. She said that, while the researchers do not always have full information on where the study participants are going for services, they are trying to get this information whenever possible.

Jimmy received clarification that both HIV-negative and HIV-positive couples are included in the Microbicide Study samples. He then asked about the rationale for the specification that the couples will use a rectal microbicide only three times a week. Susan explained that the studies actually require participants to use a rectal microbicide **at least** three times a week for 6 weeks.

Barbara asked a series of questions about the Home Specimen Collection Study:

1) Are participants informed of the newer studies on the effects of early antiviral treatment?
2) Will the study look at the relationship between the introduction of a "morning-after pill" and the practice of risk behaviors (e.g., whether people are less motivated to reduce their risk, because of the expectation that HIV infection can be reversed)?
3) What forms of counseling are available to participants?

Susan responded that:

1) The participants, who are HIV-negative when enrolled in the study, are told about the benefits of early detection and early intervention.
2) The study is examining the potential effects of a "morning-after pill" on behavior patterns.
3) The participants receive regular counseling at six-month intervals. They can choose between face-to-face and phone counseling, for any needs they may have beyond the six-month counseling session. If infected, a participant will receive face-to-face counseling.

Hank asked how the information on condom failure would be presented to the community from which the participants are selected. Susan responded that the study is holding a series of community forums, at which active staff and members of the community advisory board will be represented. She said that the study intends to ascertain the factors leading to condom failure, in order to be able to prevent (rather than just report) its occurrence. Hank also wanted to know if the researchers had noted any behavioral shifts in response to condom failure (e.g., participants "giving up" on condoms, after experiencing failures). Susan agreed that Hank had identified an important question for research. She said that most participants reporting failure only report having experienced a single condom failure. The study was designed to look more closely at those reporting multiple episodes of condom failure, to identify larger patterns (such as improper use).

VII. BREAK

VIII. EVALUATION/TA -- RISK ASSESSMENT REQUIREMENTS VOTE

Joshua Volle began the presentation by explaining that the recommendations of the Evaluation and Technical Assistance Committee are responding in large part to the Year One Goals and Objectives (see Chapter 6 of the 1995 Plan). He said that the Council is now in the phase of beginning to implement the results of the first-year process.

Next Joshua offered a statement on the committee's philosophy of evaluation:

- Providers need to focus on behavior change, to stop the epidemic.
- Providers need to begin by measuring current risk behaviors of their target populations. Then they can track behavioral change, through a series of assessments over time.
- Prevention services must focus on the long-term, and ensure effective interventions to reach those at highest risk for HIV.
- The committee supports the approach called "empowerment evaluation" -- in which CBOs develop the tools needed to evaluate their own programs. This allows the CBOs more control, more buy-in, and more ability to use the results to improve their programs.

- The committee is encouraging a proactive approach to evaluation, by asking providers to push beyond simply performing process evaluation, so that they can eventually accomplish impact and outcome evaluation -- although these are not yet required by any funder. (Note from Valerie: Funders do ask for some basic level of impact-level evaluation.)
- The committee believes that evaluation ought to be integrated into program planning, rather than just being "tacked on" when the program ends.
- Evaluation will still involve provider choices (e.g., about how to perform culturally-specific and culturally-aware evaluations, and how to include both qualitative and quantitative data).

Joshua listed the underlying principles of evaluation, as identified by the committee:

- Evaluations will document the effectiveness of programs.
- Evaluations will improve program management.
- Evaluations will improve prevention planning overall.
- Evaluations will give a voice to service users.
- Evaluations go above and beyond client satisfaction surveys, to show whether the ability of clients to reduce their HIV risk has actually been improved by a particular program.

Joshua summarized the committee's systematic evaluation plan. The first year of evaluation will focus on agency-level data collection, in the form of the required one-time risk assessment. In the second and third years, providers will continue to measure risk behaviors in their client populations, so as to demonstrate the impact of prevention services. The agency-level data collected will allow for comparison, **across agencies** and **over time**, of the effects of interventions. The third year of evaluation should also produce recommendations for in-depth behavioral research activities, for higher-level evaluation. Joshua noted that additional funding may have to be sought, for the performance of these higher-level evaluation activities.

He explained that the committee believes that the evaluation requirements will bring about growth and positive change in prevention services. To make it feasible for agencies to conduct the kinds of evaluation expected, the AIDS Office will build units of service for evaluation into the new contracts; and AIDS Office staff, Evaluation/TA Committee members, and OD/TA[1] consultants will provide technical assistance and training as needed. Any provider that makes a good-faith effort to comply with evaluation, and with all other contract requirements, will not have to face de-funding. At this point, agencies are being given time and support to comply with the new evaluation requirements. The committee has outlined a gradual and non-punitive approach to agency-level evaluation. Kristen emphasized that the committee views the evaluation plan as a positive development for agencies, and as an ethical necessity in a time of shrinking resources. Roberto explained to the Council that evaluation expectations have never before been enforced for prevention agencies, so that the whole idea of having to do evaluation is new to many providers.

Joshua briefly described the role of the OD/TA team working with the committee. Through a nearly-completed needs assessment process, the OD/TA project will determine the kinds of TA to be delivered to prevention agencies. The findings of the OD/TA team will be integrated into the strategic evaluation plan. So far, the consultants have reported encountering a wide range of levels of need, comfort, skill, and fear around evaluation.

[1] OD/TA = Organizational Development and Technical Assistance

Roberto presented the proposed data collection requirements for the first year of prevention contracts (see the attached draft). He also called the attention of the Council to the handout on evaluation-related questions and answers (see the attached draft). This document records and responds to the questions raised by committee members and by providers at AIDS Office trainings.

Discussion

Barbara asked if the socio-demographic variables attached to the "Questions and Answers" handout constitute the set that prevention providers will be expected to use. Joshua said that different interventions would be asked to collect different sets of socio-demographic variables (the sets have not yet been recommended by intervention type). The handout shows the variables being used by the CARE Council, which has incorporated committee recommendations, as well as suggestions made by prevention providers at the recent Data Elements meeting at the AIDS Office.

Mark asked how providers would offer the same level of services to clients, if they were being asked to perform new evaluation tasks, with basically level funding. Valerie responded that this question should be tabled for a longer, more complex discussion to take place at a future meeting; she assured members that the staffing and funding issues do not pertain to the vote for this meeting.

Question of the risk assessment requirement for programs conducting multiple interventions: Jimmy asked about how the risk assessment requirement would be applied to programs running multiple interventions. He was concerned that such programs would have difficulties performing more than one risk assessment in the first six months of their contract period. Committee members responded that they had not looked at this issue. Kristen said that the requirements had not yet been set by intervention type, and that these decisions would have an impact on the feasibility of the risk assessment for programs running multiple interventions.

Ana Claire proposed an amendment to strike the following phrase from the language of the risk assessment vote: "...for every intervention they are contracted to perform," and to stipulate that the committee will consider (and present for a future HPPC vote) a solution for those programs responsible for multiple interventions. Some members proposed an extension of the time period in which the risk assessments must be completed, for programs with multiple interventions. Valerie responded that the six-month time frame is imperative for the AIDS Office, because AIDS Office staff must check to see how programs are doing and help them to move forward, before the end of the contract. Roberto said that the committee had intended the one-time risk assessment to apply for all interventions, so that complete information could be accessed on the risk behaviors of San Francisco prevention client populations. Ana Claire responded that the Council members were not saying that each intervention would not produce a behavioral risk assessment, but that there should be further consideration of how the requirement would be fitted to agencies doing multiple interventions.

The Council experienced some temporary confusion around the procedure for making, discussing, and voting on amendments. Brian asked the Council to clear the table of all proposed amendments but the first one, as presented by Ana Claire. Other suggestions offered by members were put off for later consideration, depending on the outcome of the first motion to amend.

Vote 1 (on the amendment to strike the "for every intervention..." phrase and refer the matter back to the committee, for a separate recommendation applying to agencies with multiple interventions)

In Favor:	**19**
Opposed:	**3**

Abstentions: **1**
The amendment carried.

Vote 2 (on the motion to accept the committee's original recommendations for the behavioral risk assessment, with the revisions passed by amendment)
In Favor: **19**
Opposed: **1**
Abstentions: **1**
The motion carried.

IX. MEMBERSHIP -- VOTE ON 3 ITEMS

In presenting the items up for a Council vote, Committee Chair John Hamilton referred to the materials distributed to members at the April 25th HPPC meeting. (The packet is prefaced with a memo dated April 22nd, and was enclosed with the April 25th minutes for absent members.)

Bylaws

John explained that the committee had revised Articles 3, 4, 5, and 6 of the Bylaws. He specified the changed items, which are underlined in the April 22nd packet.

Meeting Participation Guidelines

John mentioned the following recommended changes to the guidelines for meeting participation:

- A phrase was added on the responsibility of Council members to bring information from their respective constituencies.
- A paragraph was added to clarify the role of AIDS Office staff and consultants in meetings.
- A deletion was made of a statement implicitly allowing side conversations during meetings.
- A statement was added to say that the co-chairs will clarify procedures, when a discussion gets "bogged down."

Public Comment Procedure

The committee had recommended that the Council formalize the public comment procedure used for the last few meetings. Ana Claire asked whether the vote would refer to the yellow sheet distributed previously at meetings (and in the minutes, for absent members), or whether it would refer to the expanded guidelines posted on the wall for this meeting. The committee clarified that the vote would apply to the guidelines shown on the yellow sheet distributed at previous meetings.

Vote 3 (on the motion to adopt the above recommendations of the Membership Committee)
In Favor: **17**
Opposed: **0**
Abstentions: **2**
The motion carried.

X. RESOURCE ALLOCATION AND RESOURCE INVENTORY

Committee Chair Jimmy Naritomi reviewed the process decisions related to prevention set-asides:

1) The AIDS Office will make the final decision on sole-sourcing of set-aside activities.
2) The AIDS Office will consider input from the HPPC on sole-sourcing/bidding decisions.

Jimmy noted that, since the AIDS Office will have to make these decisions before the release of the June RFP, feedback must be submitted by noon on May 28th.

Next Jimmy presented the input that had already been received by May 22nd. Of the five respondents, three filled out the grids on bidding and funding levels. (See the enclosed summary.) Jimmy reminded the Council that past decisions of the HPPC could not be revisited in the discussion of resource allocation issues. Then he asked if there were any reasons for the apparent reluctance of HPPC members to submit the feedback forms (sent out to members on May 16th). Mark said that he still felt that he had insufficient knowledge of the resource allocation issues to submit recommendations. Roberto stated that, as community members, the Council members are likely to feel their own biases, as they consider submitting resource allocation input. Tony said that he felt he needed more time (to review the committee materials) before he could give input.

Discussion/Feedback

Roberto said that, in view of the recent presence at HPPC meetings of certain agencies speaking to gain support for their continued funding, he was concerned about how the notes from this feedback session would be communicated to providers. Valerie suggested that Roberto's concern could be addressed through a detachment of speakers' names/identities from their input on set-asides.

Jimmy said that funding levels are a difficult issue for the Council to discuss. He pointed out that, in reality, members have to work to justify any **increase** in funding for a set-aside. Generally speaking, the Council can assume the likelihood of level funding. He added that Council members should not feel obligated to comment aloud at this meeting, since they could still submit feedback in writing, to Lyn or Eden at Harder + Co.: 444 DeHaro St., Suite #202, SF, CA, 94107.

One member commented that it is important, with sole-sourced contracts, to ensure that the providers are meeting all of the expectations of the Plan, since that is a requirement of the providers submitting proposals. The member suggested a separate review panel to look at the sole-sourced providers. Another member agreed with Jimmy that prevention is entering an age of level (if not decreased) funding levels. For this reason, the speaker thought that the AIDS Office should closely examine which interventions have clearly demonstrated their effectiveness (such as needle exchange), when considering the rarer situations in which funding might be increased.

In response to a point of clarification requested by Marshia Herring, Valerie said that the AIDS Office would set up a special provision for what sole-sources will have to do to demonstrate their compliance with the Plan. The providers for potential sole-sources will have to submit something that functions similarly to the way in which a proposal functions for the bidding providers.

Chandra asked a general question about how the resource allocation process would affect collaborations in progress (and currently contracted through the end of next year). Valerie said that all the CDC funding would be going out to bid (with the exceptions of any sole-sources selected by the AIDS Office). If a contract is competitively bid and the current provider does not win it, then the funding to that provider will be stopped. However, the provisions for the end of the fiscal year (June 1997) have not yet been determined. Valerie added that the Resource Allocation Committee has no answer yet (from the AIDS Office) on whether or not collaborations will be required or encouraged.

XI. FINAL ANNOUNCEMENTS -- Valerie Kegebein

- The meeting time preference results (from the forms distributed, completed, and counted at this meeting) had shown 3-6pm to be a more convenient time for most members than 4-7pm.
- There will probably be just one meeting (for three hours) in June.

- The orientation to the HPPC process and history will be offered on June 13th, tentatively from 2-4pm. This time was preferred by most members who expressed interest in the orientation, and it will have to impact the time set for the June meeting. (Note from Valerie: The AIDS Office is suggesting an orientation time of 1:30-3pm; interested members will be polled for their ability to participate, and asked to RSVP.)
- Valerie had noticed a comment in the most recent evaluation results that appeared to have come from someone not on the HPPC. She asked the Evaluation Team to separate public comments from members' comments and to keep outside comments off the evaluation forms.

XII. INTRODUCTIONS FROM THE NEW MEMBERS

Tony Hall described himself as a recent transplant from Arizona to San Francisco. He is originally from Southern California. He tested HIV-positive in 1992 and became a member then of the Bay Positives. Now he serves as a speaker for Health Initiatives For Youth. He apologized for being a little tired as a result of having just returned from the AIDS Watch conference in Washington D.C.

Gregory Walker moved to the Bay Area from the East Coast (Connecticut and New York City). He was responsible for a TB control program at Bellevue Hospital. In San Francisco, he is working for the NTFAP, as the program director for Brothers Network. He lives in Oakland, and is HIV-negative. He added that he enjoyed the food at this meeting, and would keep in touch about his feelings about future HPPC refreshments.

Brian announced that Piper Hyland and Pam Isaacs, who could not attend this meeting, had also been newly appointed to the Council. When they come, they will be asked to give their own personal background statements.

Enclosed with These Minutes (for all members):

- Draft Evaluation/TA document: "Year 1 -- Provider Level Data Collection & Evaluation"
- "Summary of Input to Date on Resource Allocation Issues"
- Calendar of upcoming HPPC-related meetings, as of 5/29/96.

Enclosed with These Minutes (for those absent):

- Letter regarding the support needed for Alexandria Figueroa to attend the conference
- Copies of overheads for the HIVNET presentation by Dr. Susan Buchbinder
- Packet distributed by the Evaluation/TA Committee, with drafted materials including:
  - Data collection/evaluation "Questions and Answers"
  - One-page summary of the required risk assessment vote proposed for this meeting
  - "Appendix A -- Sexual Behavior Examples"
  - "Appendix B -- Sociodemographics"
- "Evaluation Results: Participant Evaluation of 5/9/96 HPPC Meeting"
- "Participant Dialogue: 4/25/96 HPPC Meeting"
- Empty Participant Dialogue boxes from the 5/23/96 HPPC meeting
- Invitation for participation in the creation of a media campaign to be directed by the BCA

Next Meeting: June 13th, from 3-6pm, at the First Unitarian Church -- 1187 Franklin @ Geary

Minutes Recorded by: Mary Irvine
Minutes Approved by: HPPC Co-Chairs Valerie Kegebein and Chata

HIV PREVENTION PLANNING COUNCIL MEETING

June 13, 1996
3:00 PM to 5:50PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

Please read: Agenda, minutes of May 23, Committee minutes, and Resource Allocation materials

***Please bring*:** Entire package, applicable committee meeting minutes, Resource Allocation and Evaluation/TA Committees materials

Agenda — Revised

1.	Welcome & Introductions	Valerie Kegebein	3:00-3:05 PM
2.	Minutes	Valerie Kegebein	3:05-3:10 PM
3.	Announcements - Robert's Rules Gallery Comments	Valerie Kegebein/Brian Dobrow	3:10-3:15 PM
4.	Public Comment	Chata	3:15-3:25 PM
5.	Update on Linkages Study	Rani Marx	3:25-3:40 PM
6.	Steering Committee Report	Chata	3:40-3:45 PM
7.	Process Evaluation - Thermometer	Christina Goette	3:45-4:00 PM
8.	Linkages - Update	Chata	4:00-4:05 PM
9.	Break		4:05-4:15PM
10.	Resource Allocation/Resource Inventory (RARI) - Vote - Collaboration Vote - Data Review Criteria	Jim Naritomi	4:15-4:55 PM
11.	Evaluation/TA - Technical Assistance Update	Roberto Garcia	4:55-5:05 PM
12.	Evaluation/TA Vote - Behavioral Risk Assessment	Roberto Garcia	5:05-5:35 PM
13.	Goals & Objectives - Update	Barbara Adler	5:35-5:40 PM
14.	Epi/Research - Update	Patrick Forte	5:40-5:45 PM
15.	Evaluation	Chata	5:45-5:50 PM

NEXT MEETINGS:

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

***HPPC* - July 11, 1996, 3-6 PM,** The First Unitarian Church, 1187 Franklin Street (@ Geary).

SF DPH

HIV PREVENTION PLANNING COUNCIL
MINUTES
June 13, 1996

Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Isabel Auerbach
Hector Carrillo
Patrick Forte
Dale Frett
Roberto Garcia
Ellen Goldstein
Natalie Gutierrez
Tony Hall
John Hamilton
Liz Highleyman
Valerie Kegebein
Marvin Lee
Ramon Martinez
Ana Claire Meyer
Jimmy Naritomi
Chandra Pugh
Bethsaida Ruiz
Terry Ryan
Sandy Simms
Zwazzi Sowo
Joshua Volle
Gregory Walker
Edward Zold

Members Absent:
Christine Edwards
Fernando Gomez-Benitez
Piper Hyland
Sacul L'Adnbre
Mark Peppler
Dominic Perez
Jay Seward
Joshua Tager

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AIDS Office Staff:
Gene Copello
Brian Dobrow
Delia Garcia
Tracey Packer
Mike Pendo
Billy Pick

Polaris, Inc./Harder + Co.:
Mary Irvine, Polaris
Lyn Paleo, Harder + Co.
Eden Tanovitz, Harder + Co.

Evaluation Team:
Cindy Berenstein
Christina Goette
Kevin Roe

Guests Present:
Christina Badasow, RAP
Elizabeth Davis, UCSF/STD Control
Thomas Lee Eades, Health Commission of San Francisco
Ann Ueda, LIFE Institute
Kiki Whitlock, AAP, HRC/LGBTAC

1. WELCOME & INTRODUCTIONS
Shortly after 3pm, Valerie brought the meeting to order, welcomed all present, and initiated the introductions.

2. MINUTES APPROVAL
The minutes of 5/23/96 were approved without exception.

3. ANNOUNCEMENTS

- **Robert's Rules Re: Gallery Comments**
  Valerie clarified that HPPC policy allows the co-chairs to call upon AIDS Office staff for clarification or explanation. However, AIDS Office staff are not permitted to enter into the Council discussion, beyond giving public comment, offering requested information or clarification, or making announcements. A handout on the details of how Robert's Rules work will soon be distributed to the Council by the AIDS Office.
- Valerie announced that AIDS Office staff have been writing the RFP. Originally, the AIDS Office had planned to issue two RFPs (one in June and one in September). With input from the Council and from particular AIDS Office staff, the AIDS Office decided to issue a June RFP **accounting for all funding sources**. The actual awarding of State and General funds will be deferred until July of 1997 (to avoid funding overlap for the programs operating on a fiscal year). If, for some reason, the AIDS Office does not receive the proper balance of proposals, then another RFP will be issued in the fall of 1996. The combined (CDC, State, and General funds) RFP should go out in the last week of June or first week of July.
- Valerie informed the Council that Hank Wilson had sent in an official letter of resignation from the HPPC. While his health is improving, he has decided to focus on taking care of himself.
- Chata announced the NAAP memorial and feast which was held on June 1st, in honor of 17 NAAP clients who passed away in the past year. (Please see the enclosed flyer.)
- Jimmy announced that Bob Kono of the AAP passed away on Friday, June 7. He asked those interested in attending the memorial service (on Sunday, June 16) to contact him.
- Barbara said that she had brought AHP flyers for the recruitment of new volunteers. (The color-copied flyers are enclosed for those absent.)
- Tony announced the passage in the State of California of the AB 2248 (Baldwin) bill, requiring written parental consent for students in grades 1-8 to receive AIDS, sex/family life, or STD education. He added that a hearing on the bill would be held on June 26, and the SFAF would be holding an orientation for speakers on June 24th. (See the enclosed memo.)

4. PUBLIC COMMENT

No public comments were offered at this meeting.

5. UPDATE ON LINKAGES STUDY (Rani Marx)

Rani Marx, an epidemiologist for the Epidemiology and Evaluation Unit of the Health Services & Prevention Branch of the AIDS Office, presented a summary of the Linkages Study, which was commissioned with supplementary CDC funding. The study examined the system of referrals for people having received HIV testing at City Clinic. Prior to the Linkages Study, it was not clear if referrals were even being documented at counseling and testing sites. The study worked with the existing service system at City Clinic, and looked at what the providers there could do and how they could be assisted.

Rani explained that the study used a sample of 800 counseling and testing clients. She said that about 10% (or 80) of these clients had received referrals to agencies **outside** of City Clinic. These clients were asked if they would agree to a follow-up call in the two- to four-week period after referral. The follow-up calls led to completed interviews with 37 clients. Of these 37, most had not gone to their referral destination. A second round of follow-up calls was made to six clients who had not gone but had said that they still intended to follow through on their referrals.

Rani noted that the study had identified many barriers (both client-related and agency-related) to successful referral. She listed the agency-related issues:

- lack of consistent training on the referral component of counseling and testing;
- lack of good, solid written resources for people to consult for giving referrals;
- varying provider attitudes regarding the value of referrals for HIV-negative clients;
- difficulties arising from a client-centered approach (e.g., that many providers feel that clients should be able to identify their own needs, and should not be referred without having shown interest in the service suggested); and
- the limitations of existing prevention resources (which may not always meet the referral needs of counseling and testing clients).

Rani said that the study has produced:

1) forms for the documentation by counselors and physicians of the referrals they make;
2) a staff survey (on referrals) to be conducted at City Clinic;
3) a resource list that can be given as a single handout to clients; and
4) a referral letter that clients may take to the agencies to which they have been referred.

In anticipation of future requirements for referral systems, City Clinic has continued to use the documentation forms developed during the study.

The researchers working on the Linkages Study have requested client record information from City Clinic, so that they may look at how client risk, diagnosis, STD history, and other factors influence what referrals are given to which clients.

Discussion

Jimmy asked how the study tracked the success of referrals. Rani responded that the study focused on the first requirement for success -- client follow-through on referrals given. For those who completed their referrals, the study also tracked who went to which agencies and what they received there. Jimmy asked whether the study had difficulty in following up with transient clients. Rani replied that this had posed a real challenge, but that some of the more transient clients came back to City Clinic in person, and could be reached at that point by the study.

Joshua Volle asked what percentage of the 37 clients interviewed had followed through with their referrals. Rani said that the researchers did not yet have an exact percentage, but that follow-through was rare. Quite a few clients didn't even recall having received the referral. Others did not feel that the referral was important. Still others tried to go to the destination agency, but did not manage to get services there.

Tony asked if the study had determined the demographic breakdown of the 10% of the sample which received referrals to outside agencies. Rani answered that the researchers had not yet completed this breakdown, but would provide this information -- as well as cross-tabulations on the demographic variables by the type of referral given -- for the final report.

Barbara said that the AHP is trying to find ways to keep track of referrals from anonymous testing services, through calls to other agencies (which can report the instances in which clients say they have come from the AHP). She asked if Rani had any other ideas on how to do referral tracking with anonymous testing clients. Rani said that the study had not attempted to follow anonymous testers, since follow-up could not allow for the total anonymity of respondents. She thought that the approach of having agencies document the source agencies for their clients was a good one, and

added that it would be helpful to send triplicate forms along with the clients, for the destination agencies to complete and return to the referral source. However, she noted that it is always difficult to demand that agencies add more paperwork to their usual load. Isabel asked about the use of a self-addressed, postage-paid postcard, which the client could return after completing a referral (this system relies on the client's word about what has happened). Rani considered this idea, and pointed out that, beyond the trust issue, there is the question of whether clients will remember to complete and return the postcard. She said that it is easiest to follow up on medical referrals, because a provider can call the agency to see if a client arrived there for services.

Having asked their questions, the Council thanked Rani for her report on the Linkages Study.

6. STEERING COMMITTEE REPORT (Chata Ashley)
Chata gave a report on the activities of the Steering Committee. (Please see the enclosed outline.) Ellen asked about the date for the upcoming HPPC Retreat. Chata explained that the date had had to be set back, in order to arrange for a facilitator. The Retreat will not happen on the 21st, but may be scheduled for June 24th or June 26th. The co-chairs took a straw poll to determine which members could attend on which date. They asked that members keep both days open for now, and said that they would notify them as soon as possible with the final date and time. (Update: The Membership Committee has assumed the lead role for the Retreat planning. The final date/time for the Retreat has been set: **Thursday, July 25th from 3-6pm.** The location will be announced.)

7. PROCESS EVALUATION REPORT (Christina Goette)
Christina reported that the members of the Evaluation Team have been to somewhere between 38 and 40 meetings so far, which is a good reflection of how many HPPC-related meetings have taken place this year. She said that, during this month, the evaluator on each committee would be offering that committee specific feedback on its process thus far. Christina noted that the evaluation forms for this meeting address some concerns brought up by the Membership Committee. Finally, she informed the Council that Year 2 planning process participants had received evaluation questionnaires in the mail, and that six had been returned at this point. Kevin will be calling those who do not respond.

-- BREAK --

8. LINKAGES UPDATE (Tracey Packer)
Tracey updated the Council on the work of the Linkages Committee. (See the enclosed outline.)

9. RESOURCE ALLOCATION/RESOURCE INVENTORY VOTES
Jimmy referred to a handout (enclosed for those absent), which summarizes the Council input on:

1) bidding/sole-sourcing decisions on the Council-approved set-asides;
2) contract stipulations or changes in the requirements for set-aside activities; and
3) funding levels for the set-aside activities.

He explained that this input has gone to the AIDS Office, for use in the development of the RFP.

Jimmy then called the attention of members to the "Resource Allocation Recommendations," which had recently been mailed to the Council from the AIDS Office. He reviewed that the Council had approved this document, with the exception of two items: collaboration and data review criteria.

Collaboration

Background

The Resource Allocation/Resource Inventory Committee had postponed development of a recommendation on collaboration, for the Linkages Committee presentation and vote at the May 9th Council meeting. Since the adoption of the Linkages Committee's "Required Elements of Proposed Collaborations" document, the Resource Allocation/Resource Inventory Committee had added recommendation **5(f)** to its document.

Tony Hall and Gregory Walker pointed out that, as new members, they had not yet seen the "Required Elements of Proposed Collaborations" document approved by the Council. They were given copies and a few minutes to review the document, before the vote was taken.

The Consensus

Of the 22 voting members present at this point in the meeting, **21** voted to accept item **5(f)** of the Resource Allocation Recommendations, and **1** abstained. The motion passed.

Data Review Criteria

Background

Consultant Lyn Paleo explained that the demand for a way to include provider-supplied data in prevention proposals arose in the Year 2 planning process. Year 2 Council members specified that providers should be able to select their target populations and use information inside or outside of the Plan, to support prevalence rates and behavioral frequency scores for those populations. The Resource Allocation/Resource Inventory Committee recognized that provider-supplied data would need to be reviewed somehow, using somewhat looser standards than those that researchers would use to approve a professional article for publication. The committee agreed that this data review would have to take place on a case-by-case basis, with certain broad criteria for the acceptability of data. Lyn explained that, in formulating these criteria, the committee had to reach a balance between an understanding of research and an understanding of prevention possibilities and limitations. To create a draft of the "Criteria for Applicants' Prevalence and Risk Behavior Data" document, Lyn conducted and summarized interviews with several researchers. The document (enclosed for those absent) was then revised and approved by the committee, for presentation to the Council on this date.

The guidance for data review summarized in the "Criteria" document breaks down provider-supplied data by:

- Literature Review
  - for HIV prevalence estimates, or
  - for risk behavior frequencies; and
- Primary Data Collection
  - for HIV prevalence estimates, or
  - for risk behavior frequencies.

The AIDS Office will also attempt to develop some prevalence estimates for target populations that are likely to show up in proposals but are not already given estimates in the Plan. If neither these estimates nor the prevalence and frequency estimates shown in the existing Plan approximate the situation of a particular target population, then the provider may use other data to support the actual prevalence rate and behavioral frequencies for that target population. The applicant should then plug these estimates into the Matrix formula, to produce a risk score for review by the panel.

Any applicant using data from a literature review will be expected to show how the population in the study described compares to that applicant's target population (in terms of similarities and/or differences which would likely affect behavioral frequencies and/or prevalence rates).

Lyn speculated that it would be rare for a provider to have done good, solid primary data collection (on prevalence or behavioral frequencies) that would not have already appeared in the Plan. For this reason, providers submitting scores which rely on primary data not already in the Plan should figure as the exceptions in the application process, rather than the rule. However, in the future, the use of providers' primary data should become more routine (once agencies have conducted the one-time risk assessment with their client populations). This year still represents a transition stage for prevention contracts. Generally speaking, providers are expected to use good judgment (which includes a familiarity with the Priority-Setting Matrix, the use of quantifiable data, the systematic delivery of survey questions, and the use of representative samples over convenience samples whenever possible[1]) in producing primary data for use in proposals or in the Plan.

Lyn noted that the data validity review panel may also adjust a provider's basic score -- if the data cited is good but the score is not fully justified by it. Each provider should consider realistically how much the basic risk score for the population can be raised with the data available.

Discussion
Isabel asked for clarification on the point that most providers would not be using outside data sources. Lyn responded that providers are certainly encouraged to use the information in the Priority-Setting Matrix and the Epidemiologic Profile (from the S.F. Plan). Jimmy added that it is unlikely that many providers have their own data ready, to support a higher risk score. Liz asked if there would be some process of updating the Matrix, with data provided and approved during the application process. Jimmy responded that, over time, these and other newer data sources would be incorporated into the Plan.

Ramon asked about the stages of the review process (e.g., to determine which proposals have reached the minimum score). Lyn replied that there are earlier stages in the review process, including the weeding out of proposals which do not arrive on time or which do not reach the minimum risk score (however, the minimum score will be publicized in the RFP, and providers unable to support a score above the minimum for their populations are discouraged from applying). Ana Claire added that all applications coming into the AIDS Office will go through some data review process, to ensure that the applicants (including those who use only the Plan data) are following the basic guidance of the RFP.

The Vote (on the motion to accept the recommended criteria for provider-supplied data)

In Favor:	**20**
Opposed:	**1**
Abstentions:	**1**

The motion passed. Jimmy said in closing that, with of the passage of these recommendations, the Council wouldn't hear from the Resource Allocation/Resource Inventory Committee for awhile.

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[1] Lyn noted that there are also established ways of increasing the capacity of convenience samples to represent a population.

10. EVALUATION/TA TECHNICAL ASSISTANCE UPDATE (Joshua Volle)
Joshua explained that he was making this presentation for Chair Roberto Garcia, who had been ill and unable to attend the last committee meeting. He reported that two trainings on evaluation and data collection requirements had already taken place at the AIDS Office, with committee participation. One more training was planned for June 18th. He said that 12-15 people from CBOs had attended each time. Joshua briefly explained the contents of the trainings, as: (1) information on the philosophy and history of the evaluation/data collection expectations, the spectrum of provider preparedness for evaluation, and the required one-time risk assessment; (2) testimonies from providers about their experiences with evaluation; (3) a question-and-answer session; and (4) the division of participants into small groups, to talk about how to incorporate the risk assessment into particular intervention types.

11. EVALUATION/TA VOTE (Joshua Volle)
Behavioral Risk Assessment
Joshua explained that the required risk assessment had been approved at the last Council meeting, with the amendment that the committee should look into ways to adapt the requirement for agencies running multiple interventions (rather than demanding a separate risk assessment for every intervention). Joshua explained that the committee had outlined a one-year process for the one-time risk assessment, as follows:

- First Quarter: development of a plan for data collection
- Second and Third Quarters: data collection
- Fourth Quarter: data analysis

At this point, the committee handout: "Proposed Provider Level Data Requirements" was distributed to all members present.

Behavioral Data Elements
Joshua summarized that the risk assessment would examine the **HIV risk behaviors identified in the Priority-Setting Matrix** -- as physically appropriate for the client population. Clients would be asked about their behaviors in the **past three months**, and would be asked to specify whether they used a condom or other latex barrier **always, sometimes, or never** when engaging in a particular risk behavior during that period.

Demographic Data Elements
The committee chose seven minimum required demographic variables to be collected in the risk assessment: **age, race/ethnicity, gender, primary language, current living situation, zipcode/ neighborhood, and primary health care source.**

Alternative to Requiring a Risk Assessment for Every Intervention
Every funded prevention provider would be expected to conduct a behavioral risk assessment with either 20% or n=100 of the clients seen by that agency in a year. This approach should produce a basic picture of the client population of each agency, so that (a) the AIDS Office can determine which populations are or aren't being served by prevention in San Francisco, and (b) each provider can compare the client population reflected in the risk assessment with the client population that that provider intends to serve. Joshua said that the committee was aware that the sample recruitment and data collection process would vary somewhat by provider and by intervention type; the details can be decided as appropriate to each case, in contract negotiations.

Discussion
Liz asked if the committee had a list of the other questions that providers could ask (e.g., related to non-injection drug use). Valerie responded that providers will be encouraged to ask whatever other questions will yield valuable data for their use. For the Council vote, though, the committee was only presenting recommendations on the absolutely required elements for the risk assessment.

Jimmy had a question about the language of the draft handout, which suggested to him that providers might only be expected to "conduct" the risk assessment in the first 12 months, rather than having to complete the data analysis within this time as well. Joshua clarified that the data analysis must also be completed in the first twelve months of the contract, and referred to a handout distributed at the AIDS Office trainings on evaluation requirements (see the enclosed).

Tony asked about the reasoning behind the seven demographic variables chosen for the required risk assessment. His concern focused on the wording of the fifth variable, which had been written as "current homelessness" on the draft handout. The committee members corrected this language to "current living situation," which was the variable approved at the last committee meeting. Tony expressed that he was satisfied with this change.

Ana Claire asked if the risk assessment could ask about barriers other than just condoms and dental dams; she suggested the incorporation of "plastic wrap" as a viable and commonly used protective barrier. Ellen explained that the particular wording of the questions would be left up to the individual providers, as appropriate to their target populations. The committee intended only to provide some examples for the language of the questions to be included in the risk assessment. However, the variables to be included will have to be consistent across similar behavioral risk populations. Ana Claire also asked for clarification that the risk assessment would not only ask about the sexual risk behaviors that might be assumed according to the general identification of a client population (e.g., that a provider serving men who have sex with men would not neglect to ask about male-female sexual acts). Committee members responded that they were only recommending that questions be limited by the anatomical possibilities for a particular client population (e.g., so that an agency serving only women would not have to ask about receptive fellatio or penetrative vaginal or anal sex).

Lyn suggested that the risk assessment should include a general question about **how many times the respondent has had any type of sex in the past three months**. This would yield an overall frequency number, from which the individual frequencies of unprotected acts could be estimated, by inference from the "always/sometimes/never" responses. She said that the assessment would not need to ask the number of times a respondent had engaged in each act in the past three months. Without some basic question about the number of sexual encounters, though, she felt that the risk assessment could not contribute anything to the behavioral frequency estimates. Lyn offered to talk separately with the committee, about how to work out the details of her recommended addition. (Update: The Eval./TA Committee will revisit these issues and make some recommendations.)

Roberto noted that there was now a proposed change on the floor, and he asked the co-chairs to step in to prevent confusion around the process. Valerie reiterated that the question format suggested in the draft handout represented only an initial example for how to collect the required data elements. Delia added that each individual agency is encouraged to collect any additional information that may inform a particular program. The committee was suggesting some basic requirements for the data to be collected in the first year, while trying not to overwhelm providers.

Hector asked about the ultimate goal of the risk assessment, as it relates to the San Francisco planning process. Joshua replied that the purposes behind the one-time risk assessment include:

- obtaining useful client risk information at the provider level;
- getting providers on the same page with basic data collection skills/evaluation preparedness; and
- eventually producing time-series risk information, with comparisons (by agency, intervention type, population, etc.) of the client data collected from one year to the next, that may show what has helped which groups to undergo behavioral change.

Ellen added that the risk assessment will also assist with the refining of the Matrix for San Francisco populations, and the filling in of existing gaps in the Epidemiologic Profile Chapter.

Hector expressed his concern over the evidence, in both national and international research, that risk is a relative concept, which varies greatly with the context of decisionmaking. He stressed the need to look at the numerous practices surrounding the actual HIV risk behavior, in order to learn how it is that people arrive at their decisions about what level of risk to take. Hector pointed out that this experiential context, and not just the number of times a person uses a condom, would be important for prevention providers to examine. Joshua responded that these inquiries bring in the issues of co-factors (discussed in the Priority-Setting Chapter). He said that agencies could begin collecting this more complex kind of information now, and that it is definitely desirable for prevention providers to consider the factors in people's lives that influence their behaviors. The Evaluation/TA Committee has also been looking at another level of evaluation (to be implemented alongside the provider-level expectations), which would include a larger behavioral research project in San Francisco and would require more funding and an in-depth analysis by research specialists. Ellen affirmed that the committee's tasks and recommendations will be moving beyond agency-level data collection requirements. Hector noted that some agencies are better able to collect qualitative data than quantitative data. Joshua reiterated that agencies will be encouraged to collect whatever they are able to collect and to use. The risk assessment does not need to be conducted separately from these other data collection efforts (e.g., it does not have to be performed in the form of a two-page, standard survey), but can be incorporated into existing instruments. Natalie added that the data from the risk assessment will remain with the provider, for agency use in fine-tuning programs. The committee fully expects that people will tailor the risk assessment to their programs, while keeping and addressing all of the required data elements.

Isabel raised a question about the reliability of people's accounts of their sexual behaviors; she wondered whether such data (e.g., on how many times a person has had sex in the last three months) could be considered at all accurate. Lyn stated that this issue of collecting reliable data relates to the kinds of TA that providers may require. Valerie said that, of course, this imperfection of self-reported data will always be a consideration for researchers and providers.

Kiki returned the attention of the Council to the draft handout. She said that, while she understood that the sample question should be read as one possible example, she wanted to clarify that it would not be informative to ask about "oral sex performed on a male or transgendered person." Kiki emphasized the need to break down the category of transgendered persons, as appropriate for the risk behavior in question. For example, if the question relates to oral sex performed on someone with male anatomy, then it should refer specifically to "pre-op. MTF or post-op. FTM persons."

Liz said that the holes in the Epidemiologic Profile surround co-factor issues, and she asked whether the questions relating to co-factors shouldn't just be incorporated into the first-year risk assessment (since providers will want such data for their proposals, anyway). Joshua re-stated that providers may ask whichever questions they feel will benefit their program planning and proposal-writing. The data they gather along with the required data elements is optional, but encouraged.

The Consensus
The Council members **unanimously** approved the proposed one-time risk assessment requirements.

12. GOALS AND OBJECTIVES UPDATE (Barbara Adler)
Barbara explained that the committee had not met since the end of April, but would have a meeting the next day (on Friday) to begin work on:

1) the goals and objectives for the CDC application; and
2) the HPPC goals and objectives for 1997.

She added that the committee would make recommendations for these at the HPPC in August.

13. EPIDEMIOLOGY/RESEARCH UPDATE (Patrick Forte)
Patrick announced that the committee had conducted interviews with three key informant panels on:

1) bisexually-behaving women (who have not been captured in the existing study samples);
2) female sex workers; and
3) male sex workers.

The next two panels, planned for June 17th, would focus on homeless adults and immigrants. These interviews were organized to assist the committee with filling in gaps in the Epidemiologic Profile Chapter and setting priorities for future research. Patrick thanked the committee members and the consultants for their work on these tasks, and expressed his hope that the panels would contribute to the formation of research and prevention projects that would help to end the epidemic. Finally, he encouraged community members to sit in on committee meetings and offer their input.

Enclosed with These Minutes[2] (for all members):

- Program for the Native American AIDS Project Client Memorial and Feast (June 1st)
- Memo (submitted by Tony Hall) regarding the AB 2248 bill and the planned hearing
- "Steering Committee Report" outline and "Linkages Committee Update" outline
- AIDS Office "HPPC Membership List" drafted on 6/21/96 (will continue to be updated)
- Tentative calendar of July and August HPPC-related meetings drafted on 6/24/96

Enclosed with These Minutes (for those absent):

- Summary of preliminary data from the Linkages Study (pp. 10 and 10a)
- Cumulative "Summary of Input to Date on Resource Allocation Issues"
- "Criteria for Applicants' Prevalence and Risk Behavior Data" document
- Draft "Proposed Provider Level Data Requirements" for the one-time risk assessment
- Materials packet from the AIDS Office trainings on evaluation/data collection requirements
- Results of the HPPC Participant Evaluation and Participant Dialogue boxes from 5/23/96
- AHP flyers announcing culturally-specific openings for volunteer HIV counselors

Next HPPC Meeting: Thurs., July 11, from 4-6pm at the First Unitarian Church (1187 Franklin)

Minutes Recorded by: Mary Irvine
Minutes Approved by: Co-Chair Valerie Kegebein (Co-Chair Chata not available before July 10th)

[2] Goals and Objectives letter attached for co-chairs, committee chairs, AIDS Office staff, and consultants.

SF

HIV PREVENTION PLANNING COUNCIL MEETING

July 11, 1996
4:00 PM to 6:00PM ***(Please note the time change!)***
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

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Please read: Agenda, minutes of June 13, and Committee minutes

***Please bring*:** Entire package, and applicable committee meeting minutes

Agenda

1. Welcome & Introductions	John Hamilton	4:00-4:10 PM
2. Minutes	Ana Claire Meyer	4:10-4:15 PM
3. Announcements	Valerie Kegebein	4:15-4:20 PM
4. Public Comment	Chata	4:20-4:30 PM
5. RFP Update	Valerie Kegebein	4:30-4:35 PM
6. TA Report - Support Center	Mike Allison	4:35-4:55 PM
7. Linkages - Update	Chata	4:55-5:00 PM
8. Break		5:00-5:10 PM
9. Process Evaluation	Kathleen Roe	5:10-5:30 PM
10. Evaluation - Update	Roberto Garcia	5:30-5:40 PM
11. Membership Report	John Hamilton	5:40-5:55 PM
12. Evaluation	Chata	5:55-6:00 PM

NEXT MEETINGS:

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - August 8, 1996, 4-6 PM, The First Unitarian Church, 1187 Franklin Street (@ Geary).

SF DPH
SF
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#3
7/11/96

HIV PREVENTION PLANNING COUNCIL
MINUTES
July 11, 1996

Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Christine Edwards
Natalie Gutierrez
Tony Hall
Piper Hyland
Valerie Kegebein
Sacul L'Adnbre
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Bethsaida Ruiz
Terry Ryan

Polaris, Inc./Harder + Co.:
Mary Irvine, Polaris

AIDS Office Staff:
Gene Copello
Brian Dobrow
Delia Garcia
Tim Kellogg
Michelle Long-Dixson
Willie McFarland
Mike Pendo
Billy Pick

Evaluation Team:
Cindy Berenstein
Christina Goette
Kathleen Roe
Kevin Roe

Members Absent:
Isabel Auerbach
Hector Carrillo
Patrick Forte
Dale Frett
Roberto Garcia
Ellen Goldstein
Fernando Gomez-Benitez
John Hamilton
Liz Highleyman
Marvin Lee
Ramon Martinez
Dominic Perez
Chandra Pugh
Jay Seward
Sandy Simms
Zwazzi Sowo
Joshua Tager
Joshua Volle
Gregory Walker
Edward Zold

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Guests[1]:
Michael Aldrich, ICHO
Mike Allison, The Support Center
Shondra Davis, Haight Ashbury Free Medical Clinic
Marilyn Dillihant, Tenderloin AIDS Resource Center
Edwin Florentino, Street Outreach Services
Antonio Gamero, Proyecto Contra SIDA por Vida
Askia Muhammed, ICHO
Yvette Robles, Tenderloin AIDS Resource Center
Jeoslin D. Roh, Tenderloin AIDS Resource Center
Lara Sallee, Haight Ashbury Free Medical Clinic
Victoria C. Schneider, Tom Waddell Clinic, DPH
Loana Valencia, New Leaf
Adela Vazquez, Proyecto Contra SIDA por Vida
David Williams, New Leaf

1. WELCOME & INTRODUCTIONS

The co-chairs convened the meeting shortly after 4pm, and began the introductions.

[1] This list of guests has been put together from calls to the agencies represented at this meeting and from speakers' registration forms. Because less than a handful of guests signed in for this meeting, there may still be a name or two missing or misspelled here.

2. MINUTES

Because there was not a quorum present, the minutes could not be approved at this meeting.

3. ANNOUNCEMENTS

Valerie

- *Attendance:* Several members had called ahead to notify the co-chairs that they would not be able to attend: Dale Frett, Isabel Auerbach, Roberto Garcia, Liz Highleyman, Patrick Forte, and Hector Carrillo.
- *RSVP for Retreat:* All those planning to attend the HPPC Retreat on July 25th at the Ferry Building should RSVP to Betty Chan Lew at the AIDS Office: 554-9492.
- *Changes to the Agenda:* Because of recent changes made to the agenda, members were asked to add an item to their evaluation sheet, so that it would match the revised agenda. Those present wrote in: "To hear about and understand the TA report" (with the one to ten scale) as an additional measure on the meeting evaluation forms. The fifth and sixth agenda items were also switched, and the explanation of the procedure for public comment was postponed until just before the hearing of public comment. Finally, the report from the Membership Committee was postponed, because John Hamilton was not present.
- *August 22nd HPPC:* Despite any rumors to the contrary, this meeting is still scheduled to occur, and will probably run from 4-6pm (but please reserve the time from 3-6pm anyway).
- *Roles and Responsibilities:* The HPPC is currently in its third year, which is the implementation phase of the planning process. Valerie briefly outlined the responsibilities of the AIDS Office and the Council:

  AIDS Office Responsibilities

  - securing grant funding from State and Federal sources and the General Fund of the City and County of San Francisco
  - developing RFPs
  - making the awards after receiving responses to the RFPs
  - developing contracts
  - developing standardized units of service (While the AIDS Office performs this task with input from CBOs and AIDS Office staff, the task is not actually a Council activity -- it was set as a recommendation for the AIDS Office in Year One.)
  - creating study design, methodology, and implementation strategies in response to Council recommendations for research
  - meeting timelines set for the AIDS Office (These timelines may be imposed internally and/or externally, and may differ from the timelines set for the Council.)

  HPPC Responsibilities (also applying to community members and AIDS Office staff serving on committees)

  - prevention planning, speaking broadly
  - priority-setting (for populations to be funded for prevention, for future research, etc.)
  - developing recommendations or guidelines (for strategies and interventions, for goals and objectives, for linkages, for evaluation criteria, for TA, for criteria for the funding of proposals, for epidemiological and behavioral research, for procedures of the Council itself, and for membership issues)

Additional Council member responsibilities (such as regular attendance, reading of all materials, participation in discussion and in consensus/voting, etc.) have been outlined in the early Year Three minutes and still apply.

Discussion

Jimmy noted that the Council had had to clarify which responsibilities pertained to which planning process participants, on some of the implementation issues for Year Three (such as setting the minimum risk score for proposals and determining more specific criteria for the selection of proposals to award with funding). He asked if there was any mechanism to ensure accountability for whether such decisions take effect and are successful. Valerie responded that the planning process has been evolving, and that the planning parties learn as they go along. She affirmed that the responsibility for certain tasks had had to be shifted, to avoid a conflict of interest or an unfair advantage to Council members in the application process. She described the ongoing process evaluation and the year-end evaluation of the HPPC as the mechanisms for accountability.

4. RFP UPDATE

Valerie explained that the RFP would be released on July 12th (the day following the meeting). The first RFP package will solicit applications for the **behavioral risk populations** to be served. On July 23rd, the AIDS Office will hold a Bidders' Conference, from 1-4pm.

Providers must come to the AIDS Office to pick up their own copies of the RFP, or send a check to receive it by mail. Between 50 and 100 copies were made available on the 12th. Valerie suggested that each organization designate one person to pick up the RFP from the AIDS Office.

Proposals responding to this first RFP package are due on August 19, 1996.

Final revisions are being made to the second RFP package, which will solicit proposals for **activity-based interventions**. Again, the AIDS Office will allow about five weeks for providers to submit their responses. As soon as possible, the AIDS Office will also distribute information about the Bidders' Conference to be held following the second RFP release.

5. TECHNICAL ASSISTANCE REPORT -- SUPPORT CENTER

Mike Allison distributed a handout (enclosed for those absent) with a general memo on the OD/TA Project, a copy of the original statement of need and scope of work for the project, a chart on the progress of the assessment reports with participating agencies, and a written status report describing the preliminary findings of the assessment. Mike had already presented the chart and status report to the Evaluation and Technical Assistance Committee, which has been working with the OD/TA team throughout Year Three of the planning process. He explained that the committee would be meeting on the 18th to discuss the implications of the assessment results. Specifically, the committee will be considering how to deliver support to individual HIV prevention programs, so that they will be ready to come into compliance with the new prevention funding requirements.

Turning the attention of members toward the chart, Mike summarized that the OD/TA team had produced draft assessment reports on 26 of the 29 agencies which had agreed to participate. Of the 26 drafts, 21 had already been approved by the agencies assessed.

Discussion

Jimmy asked what was meant by "Not at this time," written on the right side of the chart for four of the agencies. Mike explained that interviews could not be completed at this time for those agencies, because (as a result of internal transitions and/or extremely heavy workloads) they were not able to take the staff time necessary for participation in the needs assessment. The committee and the OD/TA team had decided that the team members should continue to contact each of the non-participating agencies and keep them abreast of the progress of the needs assessment, while moving forward with the decisions to be made around TA delivery and distribution.

Barbara asked how the OD/TA team would manage to achieve some consistency between the assessments of the different agencies, since the site visits and interviews were conducted by three different consulting firms and several different individuals. Mike responded that the main control on the project was the required process of review and approval of draft reports with each agency assessed. He agreed with Barbara that the different perspectives of the assessors from the three consulting firms might lead to less consistency of the results across agencies, but he noted that the consultants had assisted each other in the writing of the draft reports. Within each firm, the lead consultant took responsibility for the quality and consistency of the work performed by others from that firm. With each assessed agency, a draft undergoes at least one process of revision, until the report is accepted by that agency. Mike added that the goal of the needs assessment is not to pass judgement on the agencies, but to assist with the decisions to be made around TA delivery.

Jimmy noted that the interview process alone had taken him 5 hours (during the assessment of his agency), and that the preparation work (a mail survey) and the review of the report had taken another few hours. His point was that the assessment process does demand a significant time commitment from the agencies involved. However, he said that the time was not excessive, when measured in light of what may be gained through participation in the needs assessment (agency-appropriate support for meeting the expectations of the Plan). The assessment can provide an in-depth picture of what the participating prevention agencies do and what they still need. Mike responded to Jimmy's comments by explaining that this understanding of what can be gained through participation in the assessment was what had led the committee and support team to decide to continue the efforts to reach the non-participating agencies, in order to collect at least some basic information from everyone.

Following these questions and comments, Mike went over the points made in the "Status Report," based on preliminary data from the needs assessment. Seeing that there were no more questions, he closed his presentation.

6. PUBLIC COMMENT

Chata explained the procedure for public comment (outlined in handouts distributed previously).

Six guests had signed up to speak, and no others signed up in response to Chata's invitation for two more speakers (the maximum number of speakers for public comment has been set at 8).

Marilyn Dillihant of TARC spoke about the work performed by CHOWs. After she spoke, she agreed to allow the inclusion in these minutes of the notes from which she had read. Please see the enclosed page, entitled "Speech for Thursday -- Safety and CHOWs."

Fred Yazzie of ICHO also spoke about outreach work conditions and priorities. He said that, in his work with ICHO and SOS, he does outreach to the Native American population and to others

at risk for HIV and other diseases. His concern centered on the difficulty of documenting unduplicated clients for street outreach. He said that he would have to keep a clipboard ready to do this documentation, and added that repeated client contacts should be the aim of people working in this field. While his contract monitor has, as he put it, been trying to "force" the CHOWs to count unduplicated clients, he feels that it is more important to look at the repeated contacts.

Edwin Florentino of SOS discussed his concerns about the HPPC-approved goals and objectives for prevention, as they relate to outreach work. While he said he has no doubt that the intention of the goals and objectives was to improve HIV prevention services in this community, he pressed the HPPC to take further action to ensure that the goals and objectives are employed in such a way as to respect and include the community. About the data collection proposed, Edwin stated that research cannot stop the spread of HIV, but people can. He felt that the Council must take responsibility for regulating and redirecting the AIDS Office in these decisionmaking processes.

Loana Valencia of New Leaf (formerly 18th St. Services/Operation Concern) talked about how the HIV Plan affects women at risk. She said that the Plan neglects the needs of women, in that it is based on a cost-effectiveness model. In her understanding, the intervention Plan gives the message that HIV prevention for women is not cost-effective. She added that, as a queer female outreach worker, she does not want what she distributes during outreach to be restricted to "condoms." She urged the Council never to compromise the health of women, whether biologically female or transitioning.

Adela Vazquez of Proyecto Contra SIDA por Vida said that the units of service document she had seen was "saying no to people in the street." She felt that the document set an unrealistic standard for street outreach work. She echoed Marilyn's point about the clients determining whether, when, and how CHOWs can work with them. In closing, she said that she believes firmly in the use of a harm reduction model for street outreach, and that she does not think she will do the type of work dictated by the units of service document.

David Williams of New Leaf also addressed problems he saw in the units of service document. He described the troubles as both practical and process-related. He compared the proposal to measure street outreach services with these particular units of service to the action of someone who gives a person a yardstick to measure his/her weight. In short, he viewed the document as an ineffective tool, which could not reflect what happens on the street. He believed that the document had been created without consulting the street outreach workers, who could have made it an effective tool. He agreed with Loana's point that the units of service document overly emphasizes a cost-effective approach to prevention services; his clients, he explained, are not as cost-effective or as responsive as some people would like them to be. With some clients, it takes more than four outreach contacts to bring about behavior change.

Discussion

Jimmy asked which document was being referenced by the speakers; he explained that he might not have seen it, since he serves on the Resource Allocation Committee. The speakers responded that they were talking about two documents: (1) the Matrix for the risk assessment and (2) the requirements for the units of service for venue-based individual outreach. Valerie noted that the units of service document being discussed was not created in a committee, but was drafted by the AIDS Office (and has since been revised, so that it is not the same document that was seen by the speakers). Tony asked if members of the Council might receive a copy of the units of service document. Valerie explained that it is a contractual document, used by the AIDS Office in

developing contracts with particular agencies awarded funding. The document was not intended to serve as a tool for evaluation or for research, but was produced for the purpose of counting prevention units of service. (Update: the revised units of service document, labeled "Appendix E, Attachment 9," is enclosed with these minutes.)

Valerie said that, in order to set a standard across all interventions, there has to be a way for agencies to count what they do. The units of service document relates strictly to payment for prevention services. While the document reflects the AIDS Office expectation that street outreach workers will impart information with each contact, will converse with clients about their areas of risk, and will give appropriate referrals -- it is not intended to dictate how CHOWs do what they do. Valerie asserted that the document and its parameters were developed from the field notes of CHOWs in San Francisco.

Jimmy asked if any members of the public at this meeting had attended any of the recent AIDS Office trainings on HPPC work and the RFP. The guests responded that they had not been to these trainings. Jimmy suggested that the information given at the AIDS Office trainings could have clarified some of the issues around the development and the role of the units of service document.

Sacul said that, as the outreach worker serving on the Council, she feels concerned that outreach workers have not been consulted in the Council process. She explained that she had invited her colleagues to attend and give comments at this meeting, and she thanked them for coming. Sacul added that the outreach workers would keep coming to meetings, until their concerns were properly addressed by the HPPC and its planning documents.

Tony asked for clarification on the status of the units of service piece as a contractual document. Valerie responded that Council members are not actually in a position to make decisions on the document -- it falls under the purview of the AIDS Office.

Delia noted that, even if the guests present at this meeting had not personally attended the AIDS Office trainings, the trainings had been attended by staff members from their organizations. She added that the units of service document and the requirements for the one-time behavioral risk assessment had been discussed at those trainings.

Referring to Loana's comments on the units of service document, Ana Claire asked if the wording about "condom" distribution could be revised to include latex barriers in general. Valerie replied that the wording had already been changed. Ana Claire's second point, referring to Edwin's comment, was that the behavioral risk assessment should not be considered "research." The requirements for the assessment do not extend to the manner in which providers collect the data on their clients. The assessment will not use academic research standards and will not lend itself to comparison between agencies, but it should manage to provide a basic picture of who is being reached with prevention services in San Francisco. Ana Claire added that the Council is requiring the behavioral risk assessment in order to follow through on the Council decision to focus prevention planning on what people do (what puts them at direct risk for HIV), rather than just on who they are. At this stage, it is important to prevention planning to know the specific behavioral risks of clients.

Valerie said that the AIDS Office is being asked by its funders to document and report what it does with the funding it receives and contracts out to providers. For this reason, the AIDS Office has to ask its contractors to gather client data systematically, and to document the types of services

provided (e.g., the provision of information in a street outreach contact). Providers need to be able to show what they have done and, eventually, to show how well they have done it. This incorporation of data collection and documentation into services is the start of the change being brought about by community HIV planning.

Valerie added that Delia would be meeting the next day (July 12th) with CHOWs, to go over each of the items in the units of service document, and discuss:

1) what CHOWs already do;
2) which tasks are unfeasible for CHOWs to do; and
3) how the units of service document might be modified to suit the conditions of street outreach.

She said that every prevention provider is being asked to make changes and to document the effects of their interventions.

Jimmy said that he knows what it is like to work on the front lines, as well as what it is like to do administration. He told the speakers that he would recommend that they talk with their management staff *before* such critical documents are written and finalized. In addition, he advised providers to apply for interventions which have guidelines that are consistent with what those providers can do.

Sacul talked about the interactions that outreach workers in the Street Outreach Services Collaboration had had with Marshia Herring, their AIDS Office Program Manager. *Note from Valerie: During this discourse, several personal comments were made about the AIDS Office staffperson, and will not be reported here. Council members were reminded of the HPPC guidelines for respectful engagement and no personal attacks.*

Chata thanked and commended the guests for their comments at this meeting. In addition, he told them to feel free to call him or any other Council member, with any questions about HPPC work. (Chata's number at the Native American AIDS Project is 522-2460).

7. BREAK

8. INTRODUCTION OF NEW MEMBER -- PIPER HYLAND

Piper introduced herself to the Council. She said that she is 20 years old and works for Bay Positives. She started this job after returning from New Orleans, six months ago. As a part-time student, Piper majors in scriptwriting. She has been making a film about a young woman who tests positive, and is also working on an HIV prevention TV spot. Her other interests include singing and modeling.

9. PROCESS EVALUATION -- ASSISTANCE FOR RESPONDING TO THE PUBLIC

Kathleen Roe explained that she had decided during this meeting to change the content of her presentation, in order to respond to an area of need reflected in the public comments given today. (The notes from the phone interviews, which Kathleen had planned to present at this meeting, will be sent along with the agenda for the next HPPC meeting.)

Turning the focus of her presentation, then, to the work involved in the second half of this year of implementation, Kathleen presented some ideas for how the process evaluation team might assist the Council in handling reactions from the public to the community planning work. She explained that the comments received from guests at this meeting were probably indicative of what would be

happening in the next few months, as the RFP packets hit the streets. Anticipating that these few months would demand a great deal from Council members, who would be called upon to explain and defend the HPPC work, Kathleen suggested that the members might benefit from a concise history of earlier tasks and decisions of the HPPC. She explained that her team had sufficient materials to provide a summary of important points in the community planning process of the past two and one-half years. In addition, she asked the Council to give feedback about what kinds of support it might want, in order to deal properly with the responses of the public to the HPPC process.

Jimmy said that he often finds himself in the "hotseat" as a Council member and a committee chair. Since not everything can be explained in minutes and other documents, he has made an effort to contact previous Council members, to fill in details about the earlier stages in the process. While he may disagree with certain pieces of the earlier Council work, he tries to explain it to people questioning the Council process, and to offer something like a training to those who need it. For example, he has shown people how to fit their target populations to the Matrix with behavioral groups. However, he said that it is sometimes difficult to convey to staff the importance of some of the Council decisions, which (to people who are service-oriented) may just appear to generate more paperwork.

Tony asked why the RFPs could not be presented and explained first to Council members, so that they would be in a better position to assist providers in understanding and following the guidelines. Valerie explained that, because the application process is a competitive one, the RFP has to be released to everyone at the same time. This rule prevents any one set of people from having an unfair advantage in applying for funding. Tony asked if there was any rule against giving the HPPC an in-depth explanation of the RFP contents *after* its release, so that members could explain the details to other people. Valerie responded that this, too, would be considered unfair. The AIDS Office can only answer questions about the RFP at the Bidders' Conference. Ana Claire added that the Council sets up the structure for the RFP, but does not have control over what actually goes into the final product. Providers may have to seek some information from the AIDS Office. However, the committee work could be shared in greater depth with the Council, in order to help members answer questions. Delia noted that, in preparation for the RFP release, the AIDS Office had already made efforts to train providers on the Plan and the committee work.

Kathleen observed that it would probably help the Council to receive a nutshell description of major HPPC decisions, what led to those decisions, and who was present when the decisions were made. Those present expressed general agreement with this observation.

Mark identified two problems that became apparent to him in the public comments section of this meeting:

1) that the Council did not have sufficient information on the topics addressed by the speakers, and so was unable to understand or respond to the concerns expressed; and
2) that the information (on the behavioral risk assessment and the units of service document) did not appear to have been communicated well within the organizations represented at this meeting (even though some members of those organizations had attended trainings).

Mark felt that both of these issues could be addressed.

Natalie mentioned that, some time ago, the Council had considered the possibility of having a person at the door to greet and welcome guests to the HPPC. That person could answer questions

and help to facilitate with signing up speakers and topics at the door, and could then prepare the Council for the topics and documents to be addressed.

Kathleen suggested that the person at the door could group and order speakers by topic, and could help to get the Council and the speakers on the same page by giving any necessary background information (e.g., the source of a document). She added that it is difficult for speakers to feel respected or included in the process, when they have to stand in a dimly lit space in the back of the room, away from the members at the table. Having been seated in the guest area in the past, she suggested that speakers might be more comfortable if they were allowed the same freedom of movement allowed to members and to guest speakers presenting to the Council by request of the co-chairs. Standing and speaking in a visible spot at or near the table, guests are likely to feel more valued and respected. Kathleen added that it might help to give more introduction to the individual speaker, in order to set off two minutes of *prepared* time for his/her comments. She also recognized the importance of Chata's appreciative closing statement to the guests.

Barbara said that members should try to obtain clarification on which pieces of information they are supposed to know, and which are best explained by other planning parties. She also remarked upon the way in which speakers tend to thank the Council for allowing them the opportunity to speak -- when it is the Council that should be grateful for their presence, and should be welcoming/inviting the public to participate (by attending, listening, reading materials, speaking, etc.). She thought the Council should develop a proactive relationship with the public. In her understanding, everyone feels some lack of information about the changes to take place in prevention services.

Kathleen said that one of the interesting findings from Charles Smith's phone interviews with members related to which groups different members say they represent on the Council, and how well members feel they are able to bring the HPPC process back to their communities and their organizations. While some members feel strongly that they are representing their program or organization (and that they are getting support to attend and prepare for Council and committee meetings), others are serving the Council more as members of their communities (and are often less supported in doing the work that they have to do for the planning process). The interviews have also demonstrated that two very different ways of approaching decisionmaking tasks operate in the Council. While some members make most decisions based on their gut perspectives, others rely on a method of reading and researching.

Chata said that he wanted to communicate to the Council the need for members to be aware of what not to take personally, where to take ownership for the work done, and how to admit their own confusion, when lacking an answer to a question about HPPC-related work. He underscored Valerie's and Barbara's earlier points about not confusing the roles and responsibilities of the Council with those of the AIDS Office. In describing his own experience of responding to phone calls and personal attacks around the issues that were then raised at this meeting, Chata pointed out that members will need to try to avoid interpreting all passion (conveyed to the HPPC) as anger.

Christine expressed support for the idea of a summary account of (1) decisions made in the HPPC and (2) the attending documents that might be referenced by members of the public. She described the Council as a team, and said that -- while they do not have to accept personal attacks around the HPPC work -- the members are somewhat responsible for the communities they represent. She added that the Retreat agenda includes a role play around how to respond to people asking questions about the RFP.

Kathleen then listed some possible activities for the Evaluation Team, and asked for a show of hands as to which forms of assistance members would appreciate:

- a list with the names and contact numbers of all community representatives who have participated in the planning process in one way or another (including members, key informant interview panelists, OD/TA assessment participants, etc.) -- at least for this year
- a list of key HPPC decisions and documents
- a list of the Council objectives, highlighting which objectives remain to be met
- a summary of what has happened in each committee over the last month, for example, and what committee work is still coming up
- a "cheat sheet" on the Council membership, with a couple of lines on each member (giving brief biographical information and the positions that people fill in their agencies)

The members present showed interest in all of these forms of assistance, with the exception of the last one (they explained that new members' biographical sketches are already shared with the Council once they are made available to the co-chairs).

10. FINAL ANNOUNCEMENTS AND MEMBERS' COMMENTS

Birthdays: Valerie said that she would like to honor and acknowledge the birthdays of people working on or with the Council, and asked people to note their birthdates. The Process Evaluation Team collected this information from Council members who were present.

Required Absence from the Retreat: Ana Claire apologized for her inability to attend the Retreat. She has to help her aunt, who is having surgery on that day.

The Delta Project -- Study on FS/MSM: Ana Claire raised some concerns about the Delta Project, a study planned to look at the KABBs of females who have sex with males who have sex with males (FS/MSM). She explained that the study had been set as the top research priority by the 1994 Council. The Council's committee on supplemental work for the prevention planning process presented its recommendations for the study, and received the approval of the first-year Council in November of 1994. The money for the study was made available on June 1st, 1995. The study would be the first of its kind to examine the KABBs of this group of women, rather than focusing on the women's partners.

Ana Claire said that she was disturbed by the amount of time that it has taken for the study to get off the ground. While the Linkages Study (approved at the same time by the 1994 Council) is nearly completed, the Delta Project has not begun to pilot its survey instrument and has not yet recruited its study sample, even for the first 40 interviews. Ana Claire stated that the original plan for the study had included 40 qualitative interviews, to be followed by 200 quantitative surveys; at this point, the 200 surveys may be cancelled (depending on the outcome of the 40 interviews).

She stressed that the Council has not been given any updates on this study (while it has heard a presentation on the preliminary data from the Linkages Study), and that there does not appear to be sufficient support for the study from the AIDS Office. *Note from Valerie: The initial plan for the study was presented at the July 1995 HPPC meeting. A significant update on the study was made on December 14 (HPPC minutes, p.2), and the study was mentioned briefly on February 8 during the orientation to the Year Three Council (HPPC minutes, p.6).* In short, Ana Claire felt that the handling of the study raises issues regarding the implementation of Council directives.

Discussion

Sacul remarked that the study might highlight some of the issues of denial influencing women's risk. She has seen in her own clients that women often don't know that their male partners are having sex with other men. Ana Claire responded that the study was expected to look both at women who knew that their male partners had had sex with other men and at women who were unaware of their partners' same-sex sexual activities.

Jimmy asked about the contractual terms of the study. Ana Claire responded that the study had been planned for completion by June 1996, but that the contract had been extended for six months, to December 1996. *Clarification from Valerie: A full year of funding was budgeted in 1996 for the exploratory study (40 interviews) and, if warranted, a larger study (200 surveys).*

Christine asked if the study was a one-time study or a long-term study. Ana Claire explained that the study was designed to do one-time interviews and surveys.

Mark said that he was glad to hear that people were thinking about this study, and noted that the population of FS/MSM seems to be a difficult one to identify and survey. He expressed his uncertainty about what the Council could do about the situation. Ana Claire said that she would like support from the Council in an effort to learn details (from the AIDS Office) on the study's progress and next steps.

Valerie said that an update on the study was planned for the Council, but that it had had to be deferred for the completion of other Council business. She said that the staff working on the project would give the Council an update on what they have done, the barriers/challenges for the research, the methodology used, and the plan of action to be taken.

Ana Claire closed by saying that she feels that the Council and the AIDS Office had opposing research priorities. While the FS/MSM study was chosen as the number one priority for the supplemental activities funding, it does not appear to have been pursued with the sense of urgency accorded to it by the Council.

Tony suggested that the study would have to be considered in terms of the feasibility of doing it in five months. He wondered whether the study might require a full year for its completion.

A complete Delta study update and clarification will be provided at the August 8 HPPC meeting.

Enclosed with These Minutes (for all members):

- Marilyn Dillihant's notes for public comment
- Loana Valencia's notes for public comment
- Revised (7/12/96) draft units of service document

Enclosed with These Minutes (for those absent):

- OD/TA report materials from the Support Center
- Outline/Diagram of Robert's Rules of Order
- "Evaluation Results: Participant Evaluation of 6/13/96 HPPC Meeting"
- "Participant Dialogue: 6/13/96 HPPC Meeting"

Next HPPC Meeting: August 8th, from 3-6pm *(please note the extended time)*, at 1187 Franklin

Minutes Recorded by: Mary Irvine
Minutes Approved by: Co-chairs Valerie Kegebein and Chata Ashley

HIV PREVENTION PLANNING COUNCIL

July 25, 1996

The Agenda of this retreat is not available.

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HIV PREVENTION PLANNING COUNCIL
ABBREVIATED[1] RETREAT MINUTES
July 25, 1996

Members Present:
Ronnie Ashley (Chata)
Isabel Auerbach
Christine Edwards
Roberto Garcia
Ellen Goldstein
Natalie Gutierrez
Tony Hall
John Hamilton
Liz Highleyman
Valerie Kegebein
Sacul L'Adnbre
Ramon Martinez
Jimmy Naritomi
Terry Ryan
Joshua Volle
Edward Zold

Members Absent:
Barbara Adler
Hector Carrillo
Patrick Forte
Dale Frett
Fernando Gomez-Benitez
Piper Hyland
Marvin Lee
Ana Claire Meyer
Mark Peppler
Chandra Pugh
Bethsaida Ruiz
Jay Seward
Sandy Simms
Zwazzi Sowo
Joshua Tager
Gregory Walker

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Committee Members (not on Year 3 Council):
Vic Hernandez *(Epidemiology and Research Committee)*
Lidia Mena-Hermida *(Evaluation and TA Committee)*
Bruce Occena *(Evaluation and TA Committee)*

AIDS Office Staff:
Kristen Clements
Gene Copello
Brian Dobrow
Delia Garcia
Betty Chan Lew
Tracey Packer
Mike Pendo

Polaris, Inc./Harder + Co.:
Mary Irvine
Eden Tanovitz

Evaluation Team:
Cindy Berenstein
Christina Goette
Kathleen Roe
Kevin Roe

1. OPENING/INTRODUCTIONS

John Hamilton welcomed those attending the retreat, and initiated the round of introductions.

2. ENERGY EXCHANGE

Ellen Goldstein and Joshua Volle led this exercise, intended to help people (in pairs) identify their areas of weakness/energy depletion and restore one another's energy. They also showed the group breathing techniques for bringing energy into the different centers of the body (belly, chest/ ribcage, and head), and led everyone in loosening up and shaking out their body parts.

[1] Because the retreat was not set up to function as a time for the conduct of regular HPPC business, the notes taken were minimal.

3. QUILT (BLOODLINES)
Chata invited those present to write their names, bloodlines (racial/ethnic self-descriptions), sexual orientation, and any other salient personal facts on individual squares of colored paper, which he then wove together to form a quilt showing the makeup of the community planning effort. The quilt will be brought to the next Council meeting, where those absent for the retreat will be invited to contribute their own squares.

4. "THE WIND BLOWS FOR..."
Ellen and Joshua engaged the group in an exercise in which a single chair is removed from the seated circle, and one person stands in the middle and declares something that is true for him/her (e.g., "The wind blows for... whoever is a caretaker for someone with AIDS," or "The wind blows for... whoever speaks Spanish."). Everyone for whom the statement is also true then rises and tries to switch seats with someone else who has stood in response to the statement. The one person left without a seat at the end of each mad dash around the circle becomes the next person to give a statement that is true for him/her. Partway through the exercise, the facilitators asked people to speak about what is true for them about their experiences in working with or on the Council. The retreat participants were able to learn something about one another and about their shared experience, by watching to see which people responded to which statements.

5. "LOST ON THE MOON"
John led this exercise, which required participants to prioritize items from a list of possible supplies for an expedition by the crew of a spaceship that has (hypothetically) crash-landed on the moon. Each person present was allowed a few minutes to come up with his/her own rankings of the fifteen items. Then the participants were split into four small groups, which were instructed to use Robert's Rules of Order to discuss and decide upon their own overall rankings. Finally, the groups were asked to come together and, using Robert's Rules, agree upon a single order for the items. When the time allotted for this exercise had expired, John read the official NASA rankings to the participants.

This exercise led to an interesting development for the Council, in that three of the four small groups agreed at the outset of their collaborative efforts *not* to attempt to follow Robert's Rules. When they individually reported this decision to the larger group, there was a discussion of whether the larger group should adopt the same decision, and drop the parliamentary procedure. The larger group reached a consensus not to use Robert's Rules, but did not have time to develop a ranked list of the items needed for survival without a spaceship on the moon. Instead, participants raised the question of whether the Council itself might function better without Robert's Rules of Order. Ultimately, there was *(1)* considerable support for this idea of changing the procedure, and *(2)* some concern expressed that another system would have to be developed to ensure, among Council members, equal access to participation. The points made about Robert's Rules of Order, and the possibility of an alternative procedure, will be brought to the Steering Committee meeting on August 2nd.

6. BREAK
Members took a break to relax, read the quilt, and enjoy the refreshments, which were provided by Spuntino's Italian restaurant and by Chata, who brought a decorated (Lion King theme) cake, to honor the birthdays of the Leos on the Council.

7. ANNOUNCEMENTS

Valerie:

- The AIDS Office Health and Prevention Services Branch is applying (with Kathleen Roe and Associates) for a CDC grant to evaluate the effects of community planning on prevention services. The application will seek the maximum funding available for this project ($75,000). The AIDS Office would like to be able to submit with its proposal a letter of support from the HPPC.

- The Seroepidemiology and Surveillance Branch of the AIDS Office is applying for another CDC grant, to examine prevention indicators (for evidence of the effects of prevention services on infection rates). The CDC expects to fund one local jurisdiction and one state jurisdiction to conduct this research, for which the maximum amount available is $125,000. Again, the AIDS Office would like to be able to submit with its proposal a letter of support from the HPPC.

8. "IT WASN'T JUST ME!"

This exercise had been planned as an opportunity for members to discuss the questions that they had had to answer from their constituencies or co-workers, about the first RFP and the work of the Council. Tracey and Christine introduced the exercise with the expectation that members would share stories and advice about how to respond to questions from non-members. Instead, the discussion took another direction, and members talked about the issues that they had not been able to address around the RFP (particularly in its departures from the work of the Council). Members expressed their frustration at trying to account for decisions which were represented in the RFP but which were not made by the Council (and sometimes appeared to contradict the decisions of the Council). The areas of constituents' and Council members' confusion included:

? The decision to put out two proposals: one for BRPs and one for activity-based interventions

? The mixing of funding sources in the first RFP, and how fiscal year contracts will fit in

? The separation of proposals for BRPs 1-7 and 8-12, and the suggestion that populations within 8-12 are unlikely to meet the minimum risk score required for proposal consideration

? The separate processes for "other programs/services," which resemble the set-aside activities
  - All DPH programs were sole-sourced.
  - Venue-Based Individual Outreach *appears* to have been included with the other set-aside activities, despite the HPPC vote against its inclusion.

? The role of the HPPC in formulating the requirements for prevention proposals/services
  - Is the community planning process truly collaborative, or is it a confrontation between the community and the AIDS Office/DPH?
  - Is the community being used for a rubber-stamping of AIDS Office/DPH decisions?
  - Which planning parties have final decisionmaking power, over which planning issues, and under what circumstances?

Following the raising of these concerns and questions by Council members, AIDS Office staff gave their responses. Valerie explained that the HPPC has the power to vote on recommendations to the AIDS Office. Then the AIDS Office takes the Council's input and makes the adjustments necessary to be able to put out the funding. The resulting guidelines from the AIDS Office proceed

to the AIDS Office's funding sources and the DPH, which put them through another process of revision and adjustment, to produce the RFP.

Valerie explained that the programs/services in Section B of the RFP are not all set-asides, though they look like the set-asides on which the Council originally voted. She added that the citywide street outreach collaboration will go out to bid competitively.

Chata asked if there were a way to ensure that the recommendations made by the HPPC (for those items presented as being within its purview) would be recorded in their integrity for providers, and distinguished from any "adjusted" versions to follow. He felt that the intentions of the Council should be documented faithfully, and should not be re-written in such a way as to make the Council appear responsible for decisions made without its knowledge or consent. He felt that the line of separation (between the entities involved in making local jurisdiction planning decisions) should be made clear. He added that the DPH should document the Council's input and acceptance or non-acceptance on each piece of the RFP.

Gene and Valerie agreed with Chata, saying that he had made a reasonable request which could be honored. Gene stated that this type of ownership of the content of particular recommendations should be maintained, and that the history behind any changes should be described. He added that Valerie and her staff had advocated for most (if not all) of the decisions made by the Council, and that there is a whole DPH process that influences the final product. Valerie supported Chata's point that the role of each partner in the planning process, and the lines of purview, ought to be articulated as specifically and clearly as possible. She explained that not even the AIDS Office staff had known that the DPH programs would be continued in their present forms, without competition from other providers.

Edward said that he would appreciate a straightforward explanation of the various roles in the decisionmaking process (e.g., when the DPH has veto power over guidelines set by the other parties involved). He added that he would like to think that the veto power is taken seriously by the DPH, and is used wisely and only as an absolute last resort. Otherwise, he explained, the veto action can erode the good faith behind the community planning process.

Jimmy asked that people not use the word "recommendation" too loosely. He said that the Council *approves* documents, which then become finalized pieces of the Plan. He stressed that those documents must be recognized as final, and that any divergent decisions made by the DPH must be highlighted and clarified in their divergence from the will and authority of the Council. In his understanding, such DPH decisions ought to be presented back to the Council, for its approval. Finally, he explained that the members of the HPPC are all volunteers, making weighty sacrifices and commitments in order to ensure a beneficial outcome for the community planning process. He felt that the other planning parties should, in turn, recognize the seriousness of the planning process and should commit themselves to the idea of involving and respecting the community of providers.

Bruce said that he had been impressed with the overall planning process. He added that it behooves the AIDS Office and DPH to respond to the demand to clarify where and when the HPPC has decisionmaking power. He echoed Jimmy's point about the need to respect the complex and time-consuming process in which Council members are engaged. He said that he had observed the ways in which the presence and hard work of the HPPC is felt in prevention, and that one of the effects of the hard work of the HPPC is that everyone in the field is working harder.

Valerie mentioned that part of the reason for her own conflicting relationship to the work of the planning process is that she has to negotiate between different loyalties and responsibilities. She emphasized that she believes in the process, and does not want the role of the Council to be "window-dressing."

Chata said that he would like to see some participation and presence at Council meetings from Mitch Katz and Sandra Hernandez (or whoever else makes the higher-level decisions). He felt that, if the Council and other planning parties could sit together and communicate, the different interests involved could work to reach a common goal, with checks and balances on the process.

Joshua explained that this wrinkle in the history of the Council seemed particularly strange because the Council had never before produced something that came back from the DPH (and went out to the community at large) in changed form. He noted that this had been the first RFP to emerge from the community planning process.

Tracey followed Joshua's point, saying that she had been calling this period the time when the "rubber hits the road" -- because the planning work has hit the concrete issues around money. She said that, when she thinks about the work of the Council, she thinks about the change she has seen (as a result of Council decisions) at the AIDS Office since 1992. She validated the suggestions that Council and committee members had made during this discussion, and she explained that -- while she is committed to the community planning process -- she also has to be able to stand for the DPH process and, to some extent, for the changes that were made in the production of the RFP.

Ellen described her own experience of the changes made at the departmental level as "heartbreaking," and said that she had been unable to defend this process after learning of the changes. She suggested that a brief document (summarizing important Council decisions described at greater length in the minutes) on the history of the Council in Year 2 might help members in dealing with the response of the public to the RFP. She added that it would have helped to have heard from the AIDS Office some news about the general issues that would come up around the RFP, and the changes to Council work (without necessarily having to cover the details of the RFP -- since discussion of these would create an unfair advantage for HPPC members). She pointed out that it had been disempowering not to be able to explain or interpret the RFP for other providers; she felt that she had been blindsighted.

Valerie said that these issues could certainly be better addressed and/or prevented in the future. She asked members to write down their concerns in the evaluation forms at the end of the retreat. The AIDS Office can make changes to their process of revision, based on members' suggestions.

Roberto explained that the HPPC members represent their agencies and have to answer to them about the results of the planning process. He felt that he had been put on the spot, and wanted the AIDS Office to take responsibility for its role in doing this. In response to this statement, Valerie said that there are some easy explanations that the AIDS Office can offer for what happened, so that members have a better understanding of the elements involved.

Terry made a recommendation that at least one (non-AIDS Office staff) Council member be in attendance to represent the Council during the entire decisionmaking process leading to the RFP. This person could then bring back general information to the Council, on changes being made during the departmental revision process, in advance of the RFP release.

At this point, discussion was temporarily closed for the final exercise and closure of the retreat. This discussion will be continued at the August 8th Council meeting.

8. "SPOKES ON THE WHEEL"
Ellen and Joshua led the group in a last exercise, involving visualization (through the image of a wheel and its parts) of the individual in relation to *(1)* the process, *(2)* the others involved in the process, and *(3)* the purpose/focus of the work. For the exercise, members stood in a circle holding hands, and imagining themselves as the periphery of the wheel, bound to the Plan (the hub) by each other and by the spokes (the process and the work/perspective of each individual).

When the group had shared this last exercise, the retreat was adjourned (at about 6:20pm).

Enclosed:

- "Themes at Midyear" from the Process Evaluation Team

Next Meeting: Thursday, August 8th, from 3-6pm at the First Unitarian Church (1187 Franklin)

Minutes Recorded by: Mary Irvine
Minutes Approved by: Co-Chairs Chata and Valerie Kegebein

Themes at Midyear

At the midyear point (June 1996) the Year 3 HPPC had developed a consistent pattern of focused, productive work. Despite continuing discussions and concerns around attendance, morale, and workload, the Council was well on its way to meeting its 1996 Objectives.

In addition to this pattern of consistent productive work, familiar themes were emerging by the middle of the HPPC year. The themes below have been observed through participant observation at Council, committee, and other meetings; evaluation surveys and other written data collection at each HPPC meeting; individual telephone interviews in April and May, and review of HPPC documents. These themes are offered as a reflection of the diversity and commitment of the Year 3 HIV Prevention Planning Council.

- Commonalities and differences in member visions of an effective Council
- The workload and the commitment to manage it
- The vagaries and many uses of Robert's Rules
- Feeling overwhelmed, behind, trouble seeing the forest for the trees
- Varying effectiveness in the mechanisms of representation
- The nature of community participation and involvement
- The nature of participation on the Council
- The importance of small groups
- Different visions/definitions of public health
- Sense that things are getting better

3:00 - 6:00 PM

HIV PREVENTION PLANNING COUNCIL MEETING

August 8, 1996
3:00 PM to 6:00 PM ***(Please note the time change!)***
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

Please read: Agenda, minutes of July 11 and June 13, retreat minutes, and Committee minutes

***Please bring*:** Entire package, and applicable committee meeting minutes

Agenda

1.	Welcome & Introductions	Membership Committee	3:00 - 3:05 PM
2.	Minutes from July 11 and June 13	Valerie Kegebein	3:05 - 3:10 PM
3.	Announcements: Clarification of Roles Quilt Location of Next HPPC Meeting	Ana Claire Meyer/Chata	3:10 - 3:15 PM
4.	Steering Committee Report	Ana Claire Meyer	3:15 - 3:20 PM
5.	Public Comment	Ana Claire Meyer	3:20 - 3:40 PM
6.	HPPC Roles & Responsibilities Discussion	Chata	3:40 - 4:10 PM
7.	Agency Request for Letter of Support	Valerie Kegebein	4:10 - 4:25 PM
8.	WS/MSM Study - Update	Geoff Henderson	4:25 - 4:35 PM
9.	Break		4:35 - 5:00 PM
10.	Linkages: Concept Vote - Referral System	Chata	5:00 - 5:15 PM
11.	Goals & Objectives: Concept Vote - Goals for CDC Application Goals for HPPC - Update	Barbara Adler	5:15 - 5:30 PM
12.	Epi/Research - Update	Patrick Forte/Kristen Clements	5:30 - 5:40 PM
13.	Evaluation/Technical Assistance - Update	Roberto Garcia/Kristen	5:40 - 5:50 PM
14.	Process Evaluation	Kevin Roe	5:50 - 5:55 PM
15.	Meeting Evaluation	Valerie Kegebein	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - August 22, 1996, 3-6 PM, ***AIDS Office, 25 Van Ness Avenue, Suite 330A (on 3rd Floor) Note: Location Change!!!***

SF DPH

HIV PREVENTION PLANNING COUNCIL
MINUTES
August 8, 1996

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Members Present:
Barbara Adler
Ronnie Ashley
Isabel Auerbach
Hector Carrillo
Christine Edwards
Patrick Forte
Dale Frett
Roberto Garcia
Ellen Goldstein
Natalie Gutierrez
Liz Highleyman
Piper Hyland
Valerie Kegebein
Sacul L'Adnbre
Marvin Lee
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Bethsaida Ruiz
Joshua Volle
Gregory Walker
Edward Zold

Guests:
Kanika Ajanaku
Elizabeth Davis
Vic Hernandez
Lani Ka'ahumanu
Cameron Lee
Dyanthe McDougal
Rachel McLean
Kiki Whitlock
Hank Wilson

Members Absent:
Tony Hall
Ramon Martinez
Terry Ryan
Sandy Simms
Zwazzi Sowö
Joshua Tager

Polaris, Inc./Harder + Co.:
Mary Irvine
Lyn Paleo
Eden Tanovitz

Evaluation Team:
Cindy Berenstein
Christina Goette
Kevin Roe

AIDS Office Staff:
Irene Carmona
Kristen Clements
Gene Copello
Delia Garcia
Christopher Gates
Marshia Herring
Tracey Packer
Mike Pendo
Billy Pick

1. WELCOME AND INTRODUCTIONS
The co-chairs convened the meeting shortly after 3:00pm. All present introduced themselves.

2. MINUTES FROM JULY 11 AND JUNE 13
The past two sets of minutes (for regular Council meetings, not for the Retreat) were approved without exception.

3. ANNOUNCEMENTS:

Clarification of Roles

- Ana Claire distributed a handout: "Notes on Roles and Responsibilities for the AIDS Office, Department of Public Health, and HIV Prevention Planning Council." She explained that the notes were in draft form, and had been taken at a meeting attended by Mitch Katz, Gene Copello, Tracey Packer, and the HPPC co-chairs. Members would discuss this set of notes later in the meeting (separate agenda item).

Quilt

- The quilt created at the Retreat is described in the minutes of July 25th. Ana Claire noted that the members who could not attend the Retreat would be asked to contribute their own squares to the quilt. Time will be set aside on a subsequent agenda, for people to fill in their information.

Location of Next HPPC Meeting

- Ana Claire asked members to make a note of the fact that the **next HPPC meeting will not take place at 1187 Franklin St. Instead, the meeting will be held at the AIDS Office on August 22nd, from 3-6pm, in Suite 330A (3rd Floor).**

U.S. National Asian and Pacific Islander HIV/AIDS Policy Agenda

- Jimmy announced that the Asian/Pacific AIDS Coalition (APAC) had just produced an HIV/AIDS policy agenda for API populations in the U.S. The report includes information on epidemiology, issues of national significance, regional and community issues, legislation, and recommendations for addressing the needs of subgroups of Asians and Pacific Islanders affected by the epidemic. Jimmy had brought copies of the report for those interested. A limited number of additional copies may be obtained by request from Jimmy Naritomi.

4. STEERING COMMITTEE REPORT

Ana Claire informed the Council that the co-chairs had received letters of resignation from John Hamilton, Chandra Pugh, and Fernando Gomez-Benitez. John may be re-locating, Chandra made a decision to go back to school full-time, and Fernando recently took another job -- which has occupied a great deal of his time.

The Steering Committee is now entering into the selection process for new members, and is sending out solicitations for nominations. Jimmy asked if the co-chairs could send a nomination form to the Mayor's Youth Commission, and Ana Claire responded that this would be done. *(Note from Valerie: We have called the Mayor's aide, to get the name of the contact person to whom the nomination form should be sent.)*

The Steering Committee produced a document (enclosed for those absent) explaining the HPPC policy around requests for letters of support for applications for CDC research/evaluation funds.

The committee also decided that a special subcommittee would be formed for the discussion of HPPC operating procedures (i.e., Robert's Rules of Order) and any possible alternatives. Ana Claire suggested that members interested in serving on this special subcommittee notify Mary Irvine, who will then inform the Membership Committee. *(Update: At this time, only one member has called Mary to inform her of his interest in working on the HPPC operating procedures.)*

5. PUBLIC COMMENT

Kanika Ajanaku of the Delta Project voiced the concerns of the Delta interviewer staff about the status of the study (funded to look at the KABBs of women who have sex with men who have sex with men). She read directly from a letter written by the project's interviewer staff to the HPPC (enclosed with these minutes). All of the interviewers were terminated on Monday, August 5th.

Hank Wilson (former HPPC member and current Epidemiology & Research Committee member) spoke about (1) the need for distribution of condoms to low-income people and to MSMs who do not identify with the gay male community, and (2) the need for prevention proposals which address substance abuse as a co-factor for MSMs. On the first topic, Hank expressed his concern that the DPH program for condom distribution had not reached adult bookstores, which constitute a venue frequented by many MSMs who do not identify with the gay male community (and so may be missed by the messages targeting that community). He felt that the DPH should make an effort to interact with people at such non-community-identified venues, especially since people going to browse adult videos are also likely to be engaging in sex during or shortly after that trip to the bookstore.

On the second topic, Hank said that the Gay Men's Speed Working Group had had a recent meeting, at which nobody was designated to write a proposal for addressing MSM speed use in the context of HIV prevention. Considering the August 15th deadline for proposals responding to the first (population-based) RFP, Hank was frustrated at the lack of initiative on the task of writing a proposal to address substance abuse, as it relates to risk and prevention, in the MSM population.

Discussion of Public Comments

Delta Study (WS/MSM)

Ellen asked how many interviews the project staff had been able to conduct before their termination. The interviewers responded that just one interview had been completed, and that it was for the pilot[1]. The first interview was conducted on Monday, August 5th.

Liz asked if the Council could discuss the project further with the former interviewer staff, during the time reserved on the agenda for a Delta Study update. Valerie explained that, according to the current Council procedure, public commenters would not be able to speak during other sections of the meeting. Ana Claire added that questions about the study could be answered after the presentation later in the agenda.

Sacul asked why the Delta Project was aborted, and Valerie responded that it wasn't. While the interviewer staff were terminated, the study will continue with volunteers and existing staff at the AIDS Office.

MSMs and Speed

Ellen asked if, in the RFP process, there is a possibility of reserving funds to ensure that needs **not addressed in the proposals received** can still be met. Valerie responded that the AIDS Office will ensure that any gaps left by the proposal process are filled. The proposal review committee will identify unmet needs.

[1] Seven interviews have been planned as a pilot, to be completed and reviewed before the forty interviews for the study.

Jimmy asked Hank if he had tried to connect with groups applying for funding to serve MSMs -- in order to see if those groups might include in their applications some discussion of speed use as a co-factor for the population. Hank responded that he wasn't sure if any such connections had been made between the Gay Men's Speed Working Group and organizations serving men who have sex with men.

Hector asked for more description of the meeting that Hank had attended. Hank explained that representatives from San Francisco AIDS Foundation (which has had a role in addressing drug use in the context of prevention) and New Leaf (formerly 18th St. Services and Operation Concern -- which have traditionally had a treatment role) had been present at the meeting. While members of the Gay Men's Speed Working Group expressed interest in the idea of a proposal for prevention services which would look at the relationship between speed use and risk behaviors among MSMs, nobody stepped forward to take the lead on producing such a proposal.

Barbara suggested that people at this Council meeting could take this information back to their organizations and consider writing something about speed use into their own proposals. She added that she would recommend that the Working Group contact people who serve the target population and who might be able to put together a strong program addressing MSM speed use.

Valerie noted that MSM amphetamine users had been placed at a high priority for prevention, in the unmet needs identified in 1995 and 1996. She expressed her hope that this information from the Council would be incorporated into the proposals. There was CDC supplemental funding allotted to support San Francisco projects targeting this behavior.

Condom Distribution
Valerie stated that the DPH has a citywide condom distribution program, which may not at this point include adult bookstores. The DPH is currently planning to increase its distribution of condoms around the city. Valerie added that -- during Lesbian, Gay, Bisexual, and Transgender Pride month -- she and other AIDS Office staff had personally delivered cases (of 1,000 condoms each) to each bar in the Castro, Mission, Polk, and SOMA neighborhoods.

6. ROLES AND RESPONSIBILITIES
The co-chairs referred to the draft handout dated August 8, from the AIDS Office staff and HPPC co-chairs meeting about issues raised at the Retreat on July 25th. To come up with the draft notes on roles and responsibilities, the group had looked at the CDC Guidance for community planning processes. The CDC Guidance delineates the authority of the HPPC and of the DPH, and describes the areas of shared responsibility. Ana Claire reported that what was missing from the CDC Guidance was a discussion of how the mechanisms for sharing authority should work. She pointed out that item #3 in the first section of the handout (regarding the responsibility of the HPPC) is somewhat vague. Ana Claire explained that, in her understanding of item #3, the HPPC establishes guidelines for the RFP, and prioritizes the activities and populations that it would like to see funded for prevention. **All of the notes in the handout refer to roles, responsibilities, and communication around the RFP process, specifically.** The HPPC has other responsibilities; this handout represents an attempt to summarize RFP-related functions only.

Chata offered some background on the decision to define the roles and responsibilities of the planning parties. He briefly described the exercise at the Retreat, which demonstrated that members felt they could not respond to questions about the RFP, because of the unexpected influence on it of non-HPPC decisions. He said that the Council was being presented now with

another opportunity to discuss those kinds of issues around the RFP, and that the discussion would help to clarify the lines of responsibility around the decisions made by the HPPC, the AIDS Office, and the DPH. The co-chairs would take suggestions at this meeting for mechanisms that members think should be put in place for communication between the different planning parties.

Discussion

During the discussion of roles and responsibilities, the following points were made by individual members:

- The Resource Allocation and Resource Inventory Committee was presented with a number of possibilities for the Set-Asides. Much committee and Council time, and many AIDS Office staff hours, would have been saved if members had been aware that the DPH/AIDS Office already had certain recommendations in mind. **It would have been preferable to be aware (at the outset) of the limited options open to the committee and Council.**
- The committee and Council votes on Set-Asides were not wasted, because the decision around **what could or couldn't become a Set-Aside was actually within the Council purview.** (The RFP representation of these decisions looked somewhat different from what the Council expected, but did not materially differ from the final vote.)
- The process of making decisions around Set-Asides was extremely laborious. Continuing Council members seemed to have a better sense than the newer members, of what was or wasn't within their jurisdiction. People were reluctant, anyway, to make the more specific funding decisions. The committee could have saved a great deal of time and trouble, had it been told what was or wasn't its responsibility. **Better communication within the Council could have helped the committee process.** In the future, Council members can assist the committees by keeping track of what they are attempting and informing them immediately if their work is off-track or runs counter to the HPPC philosophy and purpose.
- At this point, it would be worthwhile to focus on how to prevent the kind of miscommunication that surrounded the RFP from happening again. **It will be important to ensure that HPPC decisions are not changed, and that -- if another decision overrides the decision of the HPPC -- Council members are informed immediately.** It was confusing to have done so much work and to think that it was all final, only to learn that it was not. Some members of the Council are also in a position of having to justify their time on the Council to their directors or supervisors. In this situation, it makes a great difference when the members can explain the products of the planning process, and can demonstrate that their participation on the Council is purposeful and meaningful.
- The Council may need to look at **the difference between a "miscommunication" and a last-minute change in its role.** (To this member, an actual change in the Council's role/purview seemed to take place *after* the Resource Allocation recommendations had been made.)
- It is important for the Council to realize that **sometimes someone has to make an executive decision.** It is better to recognize this possibility, than to believe that the process is democratic (when it is not).
- For the past eight or nine months, it has seemed that the AIDS Office and DPH have a number of ideas about how the HPPC should be working, and what recommendations it should produce. The members have not been explicitly told what was expected of them, but sometimes it feels as though they are being guided (or dragged) to a particular outcome. It would help the Council to **have the people with ideas about where its process should be going (e.g., Mitch Katz, Willie Brown, or Sandra Hernandez) attend the meetings and**

put their input out on the table. This way, everyone will be able to see and discuss the directions for the Council.

- In the document, the suggested mechanism, **"Review of RFP narrative by Council members without Conflict of Interest,"** represents a positive change. The Council needs some mechanism by which it can talk about the RFP sooner, and recognize what the agenda is -- in order to give input. It seems important to adjust the attitude of prohibition/taboo around letting anyone know anything about the RFP before its release to the public.
- It is still unclear what is meant by #3 (for the HPPC) in the "Roles and Responsibilities" document. **What does responsibility for the "structure of the RFP" entail?** It is also notable that the statement on HPPC responsibility is so much shorter than those referring to the AIDS Office and DPH responsibilities.
- There has been a real **learning curve** established, both on the committees and on the Council. The tasks have not always been clear from the start. On the committee level (at least for the Goals and Objectives Commitee), AIDS Office guidance has been necessary and helpful for clarifying what was to be done when. On the Council level, it can be helpful when the AIDS Office steps in; however, this action can also make it more difficult for members to give input.
- While the Plan has been a source of pride, **the RFP did not seem closely enough related to the Plan.** The HPPC seems to have control over what goes into the Plan, but not over how it gets implemented (in terms of resource allocation).
- The Council does have a very important veto power (although it does not relate to the RFP roles and responsibilities -- and so does not appear in the current draft "Roles and Responsibilities" document); the HPPC writes a **letter of concurrence or non-concurrence with the AIDS Office application to the CDC for Cooperative Agreement funding.**
- In the document, **the fifth item under "Mechanisms"** should be particularly helpful. In the past, there has been some confusion around documents coming from the AIDS Office, as opposed to documents coming from the HPPC. The delineation of document sources/ authorship will be much appreciated.
- To item five, it should be added that documents approved by the Council will be distinguished from those which have not been finally approved. Each document developed for or by the HPPC should be stamped (or should include a header or footer[2]) **with the date of its presentation, and with a note of whether it is the final version or an intermediate draft.** When this is done, members will be able to find and refer to the correct document more readily.
- The community planning effort functions as a collaboration between the HPPC and other entities (e.g., the AIDS Office and the DPH), and there was a need to identify the specific roles and reponsibilities of each entity. But while some members seem to believe that documents have been changed (without HPPC consent), the documents have not changed so much as the vision and ideology may have changed. There is a need to ensure that recommendations finalized by the HPPC will not be changed, and that any opposing decisions will be explained by those making them. **The Council should be commended** for

[2] Because of the vast amount of paper that passes through the HPPC and its committees, the logistical support person will greatly appreciate the use of headers or footers (to indicate AIDS Office, committee or Council ownership of a document, the date of presentation, and the draft status) by those producing the documents to be distributed. Unfortunately, there are not stamps with all of this information; and it would not be as time-effective or neat to hand-write or type the information on the top of each document. The information should be noted before distribution of the material at the committee level -- so that committee members will also share in the ease of organization which is the objective behind this suggestion.

all of its work over the past 2 and 1/2 years, and for the enormous generation of recommendations and documents that did go into the RFP (with a few "glitches" around implementation). All in all, the RFP is an impressive document.

- It is important to consider that the resource allocation process is the point at which the whole Plan comes together and makes a difference. With this understanding, people at the AIDS Office should **assign particular weight to the recommendations from the Council on resource allocation issues.**
- The AIDS Office **can inform the Council about many issues in the RFP,** while screening out the detailed information that might create a conflict of interest.
- There seems to be a need for a **mentor program** on the Council -- not just for youth joining it, but for all new members. Veteran members should be assigned to give support to new members and facilitate their involvement with the Council.
- **Orientation meetings** for Council members should also happen sooner after their selection.
- Council input on some issues (such as the roles and responsibilities of planning parties) might best be given in **small group settings** (for interested members), rather than at the general Council meeting.
- It might be useful to have **each committee evaluate its own role and work, as they were reflected in the RFP,** and then bring back the information to the larger Council setting.

The co-chairs began to wrap up the discussion on this agenda item. Chata said that the Linkages or Steering Committee would be given the task of fleshing out the "mechanisms for better communication between the HPPC and AO around implementation of HIV Prevention Plan." Valerie told members that she heard and respected their comments. The following **action items** were noted:

⇒ Gene Copello, Mitch Katz, and Sandra Hernandez will be asked to address the Council at the first September HPPC meeting.

⇒ Council members will be given organizational charts (please see enclosed) for the DPH -- so that they can see, for example, where the AIDS Office fits into the larger structure.

⇒ The third item (HPPC responsibility) in the draft document may be revised as follows[3]:

The HPPC is responsible for the overall structure of the RFP; the choice of priority populations and activities to be funded; and the mechanisms by which the funding will be allocated.

⇒ The fifth "mechanism" in the handout will be revised to show that documents will also be marked with the date of the meeting for which they were prepared (and the draft status).

⇒ A sixth "mechanism" will be added:

On the morning of the day of the RFP release (or as soon as possible), a special meeting will be held for Council members to discuss any gaps in translation of the HPPC decisions to the RFP text, or any other responses and input.

⇒ The co-chairs will work to establish a mentoring program for new Council members.

⇒ Two Council members (not affected by conflict of interest) will be asked to review the RFP prior to its release.

⇒ Gene Copello will be added to "mechanism" 4, since he is committed to supporting the community planning process, and can speak to the responsibilities of the AIDS Office.

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[3] The notes on roles and responsibilities have yet to be discussed by all parties involved. Therefore, changes to these drafts may occur.

At this point, Chata read a poem, "The Selfless Servant," in dedication to the Council and all who are involved with the community planning process. The poem is attached to these minutes.

7. AGENCY REQUESTS FOR LETTERS OF SUPPORT

Two requests were made for letters of HPPC support: one from the STOP AIDS Project, and one from the Epidemiology & Evaluation Unit of the AIDS Office. Members were asked to refer to the handout: "Policy Regarding Requests for Letters of Support," (enclosed for those absent) which offers information on the Council's decisionmaking process around supporting research proposals for CDC prevention funding.

- *Hector Carrillo of the Stop AIDS Project* spoke about his agency's application for CDC funds for outcome evaluation (of the Stop AIDS Neighborhood Organizing Program, involving community leaders in supporting an environment of safer sex behavior among gay and bisexual men at risk for HIV). He explained that Stop AIDS Project was proposing to conduct the kind of qualitative, long-term evaluation needed for community organization projects. He added that, at this point, Stop AIDS seems to be the only San Francisco organization applying for the CDC funding for "Outcome Evaluation of HIV/AIDS Prevention Interventions," and that it would be important to have a project representing San Francisco. The longitudinal study Hector outlined would conduct ongoing, qualitative interviews with a sample of key opinion leaders, to determine the processes that must take place in order to incorporate HIV prevention into the agenda and role of those opinion leaders. Hector summarized that the project would examine whether the community organizing approach allows for effective prevention leadership-building. In response to a question from Jimmy, Hector said that he did not at that moment know just how much funding would be requested or how many interviews would be proposed. (For additional information, see the proposal description, enclosed for those absent.)

  The Vote:

In Favor:	**18**
Opposed:	**0**
Abstentions:	**2**

  The motion (for the HPPC to submit a letter of support for the proposed Stop AIDS Project intervention evaluation) passed. The co-chairs will write the letter for the HPPC.

- *Alice Gleghorn of the AIDS Office Epidemiology & Evaluation Unit* informed the Council that the AIDS Office is applying for CDC funds to develop and implement community-level interventions for young (ages 15-25) MSMs of color. The San Francisco AIDS Office would collaborate on this project with the Alameda County, City of Berkeley, Contra Costa County, and San Mateo County health jurisdictions; CBOs in those counties; and the CDC. Alice explained that the project had been proposed in part as a way of building on the data gained in the Bay Area Young Men's and Young Women's Studies.

  This is a **two-stage proposal, with a competitive application process at both stages.** In Phase 1, formative research would take place -- particularly in Contra Costa and San Mateo Counties, where there has not been the kind of formative research conducted in other parts of the Bay Area. This phase would focus on interviews for a community

assessment process (to identify what will help to promote safe activities in this high-risk population, and to examine differences in risk/prevention issues by subgroups within the larger population of young MSMs of color.)

In Phase 2 (two years after the beginning of Phase 1), the project would focus on implementing community-level prevention interventions in the different counties. Even if the first proposal is awarded funding, the contractors are not guaranteed any funding for Phase 2 (which requires a separate application process).

Alice stressed that the project would function as a collaborative effort. The county health administrations would work with planning councils, advisory groups from the target population, and CBOs in the Bay Area. In response to a question from Ellen, she clarified that the development of the proposal had also been a collaborative process.

Jimmy asked what groups would be included as MSMs "of color," and how the health departments planned to access those groups. Alice responded that the project would utilize connections between the heath departments and the CBOs that do have contacts in the target population. In San Francisco, NTFAP (home to the Brothers Network and Proyecto Contra SIDA por Vida) had already agreed to collaborate on this research project. Because of the work already done in San Francisco, though, the project's activities in this city would be more limited than in some other parts of the Bay Area.

Jimmy explained that he was concerned about the breakdown of "young men of color," and the inclusion of Asians and Pacific Islanders and Native Americans. In his experience, there is usually not supportive documentation showing which groups "of color" are represented. HIV risk and prevention issues vary greatly among groups that fit within the general category: "of color."

Alice explained that the project would identify the subgroups at differential risk for HIV. At this point, the researchers were expecting to look at Latino and African-American MSMs. They had decided not to include Asians and Pacific Islanders because of a competing application emerging from CAPS, which is proposing to focus its research on API populations. Alice said that the project was proposing a model of working with identified subcultures, to develop community-level interventions. The exact dimensions of the interventions would be determined by the results of the formative research phase.

Other members echoed Jimmy's concern about the tendency toward exclusion of Native and API communities from research projects. Given that the Native community has shown itself to have the highest seroprevalence of any ethnic group, it would be important to address this community in a prevention research project for young MSMs "of color." Joshua suggested that, if the project does not plan to include young Native MSMs, the name should be changed -- to reflect that only Latino and African-American MSMs will be included. Gregory underscored this point, saying that he would encourage the researchers to clarify that this is a study of "young Latino and African-American men," if that is the case.

Liz asked whether the study would look generally at MSMs and MSM&Ws, or only at self-identified gay and bisexual men. She pointed out that the language of the proposal was not clear on this issue. Alice responded that she was unsure at this point whether the

sampling would select for self-identified gay and bisexual men, and that the project would have to work with the CDC to make this decision. She added that community-level interventions may best be designed from findings with self-identified gay and bisexual men.

Roberto noted that he had not yet heard of NTFAP's agreement to collaborate with the study, despite his position at that agency. He asked Alice if the Living Well Project would collaborate with the study. Alice replied that Living Well has signed onto the CAPS proposal.

Jimmy pointed out that, considering the limitation of six contracts nationally for this pot of funding, it would be unreasonable to expect two (or 1/3) of those contracts to go to San Francisco. Alice clarified that the CAPS proposal is focusing on Alameda County, Los Angeles, and possibly one other area.

Hector expressed his concern that Alameda has "contamination" from interventions being performed in San Francisco, and wondered how the study would account for the overlap between the two counties. Alice said that the research project being proposed by the AIDS Office might utilize an East Bay catchment area (sampling site), but that the researchers were hoping to cut down on overlap as much as possible. She added that there has been roughly equal exposure (of all the Bay Area cities to be included in the project) to San Francisco-based interventions.

Vote 1

In Favor:	**8**
Opposed:	**7**
Abstentions:	**7**

The first motion (for the HPPC to approve the submission of a letter of support for the proposed Bay Area collaborative research project) did not pass by a majority of one-half plus one. As a result, the Council added the following amendments:

1. an amendment to change the language of the proposal, so that it specifies the ethnic groups to be included in the study (rather than generalizing for young men of color) -- i.e., young Latino, African-American, and Native American MSMs
2. an amendment to ensure that the body of the proposal acknowledges that another proposal is being submitted separately to look at API populations (If the CAPS proposal is not funded and the AIDS Office proposal is funded, then the Bay Area collaborative research project will undergo a separate process to add young API men to its proposal.)

Vote 2

In Favor:	**16**
Opposed:	**4**
Abstentions:	**2**

With the incorporation of the above amendments, the motion to submit a letter of support passed. The co-chairs will write the letter for the HPPC.

8. DELTA STUDY -- UPDATE (See "The Delta Study" handout, enclosed for those absent.) Valerie and Irene Carmona rose to speak, as AIDS Office staff members, about the direction that the Delta Project will be taking. Valerie informed the Council that Geoff Henderson, who was the Principal Investigator for the study, has resigned from his position. His letter of resignation states that he has finished work on the study design, and that he is confident that the AIDS Office will be able to carry out the implementation stage of the project. Valerie, who has been acting as Co-Principal Investigator, will now serve as the Principal Investigator for the study.

The study is entering the full implementation phase. Valerie explained that some of the delays which have characterized this project up to this point were a result of the uniqueness of the study, the uniqueness of the population, and the challenges of conducting such a study out of the AIDS Office.

At this point:

- The project's application to do research with human subjects has been approved by the Committee on Human Research (CHR) of the UCSF Institutional Review Board (IRB).
- The interview instrument has been revised with input from AIDS Office staff and the Delta Project Community Advisory Committee, and is now ready for use with respondents.
- 60 women have called the AIDS Office about participating in the study, and they are being screened over the phone for their eligibility.
- Interviews will continue through September.
- Staff from different branches of the AIDS Office and from City Clinic, as well as volunteers, will work on the project. All of these staff and volunteers are already trained in interviewing techniques, and will be trained on this particular survey.
- The APHA (American Public Health Association) has accepted an abstract for presentation on the study at its meeting in November.

Discussion

Jimmy noted the short timelines for the project, and the decrease in line staff on the project. He asked Valerie if she thought that the project would be able to achieve a sufficient sample of women for the number of surveys needed. Valerie said that she believes the project will find the 40 respondents. Then the data from this group of interviews will be used to determine whether a full-size survey (of 200 respondents) should be conducted with this population. She added that the study had been given an extension until December of 1996, and that AIDS Office staff and volunteers had been brought on to function as line staff (interviewers).

Isabel asked to clarify the population being studied. She pointed out that, if the study is looking at women who have sex with men who have sex with men, then it is looking at WS/MSM&W (rather than just WS/MSM -- which, in strict HPPC terms, is an oxymoron). Valerie affirmed Isabel's point, and explained that "WS/MSM" had been used as a simpler (but less accurate) shorthand for the study population. Isabel also asked if the project staff had any views as to where these women would fit into the twelve behavioral risk groups (e.g., is there a consistent pattern of bisexually-behaving men and bisexually-behaving women having sex with one another?). Valerie responded that, at this point, it is still unclear who these women are and what risks for HIV they may have. She said that the study should help the AIDS Office to determine which groupings apply to these women, whether these women are at significant risk for HIV, and whether messages addressing this population should be integrated into prevention programs. Valerie added that the most striking difference between this and previous studies is that the Delta Study is choosing to interview the

women themselves, rather than the men with whom they have sex. This choice reflects the project's aim of contributing to the design of future interventions for women.

Liz asked why the original interviewing staff were fired, after the completion of only one interview. Valerie answered that she could not give any information on this confidential personnel issue.

Sacul pointed out that many WS/MSM&W are not aware that their male partners have had sex with men. Reasoning that the study would want to include such women, who may be putting themselves at risk because they do not know about their partner's activities, Sacul asked why the male partners were not being interviewed instead. Valerie responded that, early in the history of this project, this approach (to MSMs and MSM&Ws, who might then refer the women in question) was suggested. However, the Advisory Committee to the project expressed serious concerns about the breach of confidentiality that would follow from such an approach, and about the difficult position of the women who would be brought in for an interview in this manner. With the current sampling and screening strategy, the study expects to be able to interview both women who have always known about the activities of their male partners and women who found out at some point that their male partners had had sex with other men. Some women may be connected with the study by community leaders who have been made aware of the research project.

Piper spoke up to let Valerie and Irene know that America Online has a chat group for women who are partners of bisexual men; she suggested that the project might be able to use this resource.

Ellen asked Ana Claire if, as a Delta Project Advisory Committee member, she felt that it would be feasible to move forward with the study now. Ana Claire responded that it would be difficult for her to talk in this context about all of her thoughts on the project, but that she would say that she was frustrated at this point. She had just learned the day before of much of the information presented to the Council at this meeting. She stated that the Advisory Committee had gone over the same basic material (the survey instrument) in each meeting. She added that she did not know the personnel issues behind the terminations, either, and that she was not sure how the study would function with volunteers and existing staff working overtime, as opposed to a dedicated project staff.

Ana Claire noted that the Council may need to look at mechanisms for quality assurance (QA) on the studies that it recommends (this is a responsibility shared by the HPPC and the AIDS Office). She explained that, with other studies (such as the Transgender Study) being conducted at the AIDS Office, this would be a good time for the HPPC and AIDS Office to set some mechanisms for monitoring research projects. She added that Valerie had mentioned the option of bringing in the Epidemiology/Research Committee to assist with developing quality assurance mechanisms.

Roberto asked about how the Council might help the AIDS Office to finish the Delta Project in the short time remaining for it. Valerie answered that members could give support in the areas of posting recruitment flyers at their organizations or referring HIV+ women to the study. Roberto added that it might still be important to hire interviewing staff. Valerie and Irene responded that the AIDS Office has, in the past, successfully completed studies using only volunteers.

Natalie asked if the members would again be updated on the findings of the study, and the project staff confirmed that there would be further updates.

9. BREAK

10. GOALS AND OBJECTIVES -- CONCEPT VOTE

As committee chair, Barbara presented the draft "Goals and Objectives for the 1997 Application to the CDC" for a concept vote. She explained that the committee had produced a separate document for the "Goals and Objectives for the 1997 HIV Prevention Planning Council," which also requires a concept vote. (Both drafts are enclosed for those absent.)

Turning the attention of members to the first document (for the CDC application), Barbara explained that the committee had decided to use ratios for both Outcome #1 and Outcome #2. She also pointed out that Outcome #3 can be written in terms of individual outcomes for each high risk behavior (the "OR" option shown on the handout).

Discussion

Terry expressed her concern about the wording of the outcome objective for preventing HIV infection through injection. She said that it is not only "unsterile needle use" that constitutes a risk for IDUs (i.e., substance use in general acts as a co-factor in this population). It was clarified that the outcome objectives for the CDC application refer only to **direct** behavioral transmission risks.

Joshua voiced his support for the "OR" option, and asked whether the final draft would address all of the risk behaviors in the Priority-Setting Matrix, or just the highest risk behaviors. Tracey and Barbara responded that only the highest risks would be represented in the outcome objectives (so that, for example, there would not be projected rates of reduction for "sharing sex toys").

Barbara said that the Goals and Objectives Committee had tried to develop objectives which represent the approaches of the other committees (e.g., the Evaluation and TA Committee recommendations for future evaluation of behavior change). Ana Claire asked if the document would be expanded with more objectives related specifically to the work of the other committees. Barbara responded that such HPPC task-specific objectives would go into the "Goals and Objectives for the 1997 HPPC," which would be submitted separately in the CDC application.

Regarding the process objectives for individual behavioral risk populations, Liz asked when the information on the interventions to be provided and the agencies to provide them would be incorporated into the document. Tracey and Barbara responded that these details would be filled in after the AIDS Office had received and reviewed all proposals submitted in response to the RFP.

Jimmy asked whether the outcome objectives for behavioral risks would be based on effectiveness information from the agencies targeting those behaviors (e.g., data from Prevention Point, to set the percentage reduction shown in the outcome objective on unsterile needle use). He explained that he wouldn't want the reduction rates to be set unreasonably high, thus setting up the prevention programs for failure. Tracey responded that this was an important point, and that it would be difficult to come up with a good estimate without using program data. She agreed that the committee would need to seek assistance in determining the numbers, and she explained that the date, 12/31/99, had been chosen because it marks the end of a three-year funding cycle for prevention. Jimmy reiterated that the rates should reflect real program data, so that the objectives can be measured and fulfilled. Barbara and Tracey showed support for his suggestions.

The Vote

In Favor:	**14**
Opposed:	**0**
Abstentions:	**0**

The motion to approve, in concept, the direction taken by the Goals and Objectives Committee in the creation of "Goals and Objectives for the 1997 Application to the CDC" passed unanimously.

Because the Council meeting had run a full three hours and members had already begun to leave the room, the second concept vote (on "Goals and Objectives for the 1997 HPPC") was postponed.

11. FINAL ANNOUNCEMENTS

- Ana Claire announced that the procedure for voting on letters of support would be revised, since this part of the meeting had not gone as smoothly as it could have.

12. MEETING EVALUATION

The meeting was adjourned, and those members remaining filled out their evaluation forms.

Enclosed with These Minutes (for all members):

- "Statement to HIV Prevention Planning Council" from the former Delta Project interviewers
- Organizational charts for the DPH, AIDS Office, and Health & Prevention Services Branch
- Poem: "The Selfless Servant"
- Description of Stop AIDS Project proposal for CDC funds for outcome evaluation
- Description of the AIDS Office/Bay Area health departments collaborative research project proposal for CDC funds to develop and implement community-level interventions
- Summary on the Delta Project, presented by AIDS Office project staff to the Council

Enclosed with These Minutes (for those absent):

- Draft (revised at this meeting) "Roles and Responsibilities" for the planning process
- Draft "Policy Regarding Requests for Letters of Support"
- Draft "Goals and Objectives for the 1997 Application to the CDC"
- Draft "Goals and Objectives for the 1997 HIV Prevention Planning Council"
- "Evaluation Results" from the pre- and post- Retreat questionnaires
- "Membership List," updated 8/7/96
- HPPC and committee calendar, updated 8/19/96

Next Meeting: August 22nd, 3-6pm *at the AIDS Office*, 25 Van Ness Ave., Suite 330A (3rd Fl.)

Minutes Recorded by: Mary Irvine
Minutes Approved by: Co-chairs Chata Ashley and Valerie Kegebein

H12
#2
8/22/96

AIDS Office
25 Van Ness Ave, 3rd Floor
3:00 - 6:00 PM

HIV PREVENTION PLANNING COUNCIL MEETING

August 22, 1996
3:00 PM to 6:00 PM
AIDS Office ***(Please note the location change!)***
25 Van Ness Avenue, Suite 330A (3rd Floor)
San Francisco

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Meeting called by: Co-Chairs:
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

Please read: Agenda, minutes of August 8 and committee minutes

Please bring: Entire package, and applicable committee meeting minutes

Agenda

1.	Welcome & Introductions	Chata	3:00 - 3:05 PM
2.	Minutes from August 8	Chata	3:05 - 3:10 PM
3.	Announcements	Chata	3:10 - 3:15 PM
4.	Public Comment	Chata	3:15 - 3:35 PM
5.	Goals & Objectives - Future Directions Vote - Goals for CDC Application Concept Vote - Goals for HPPC	Tracey Packer	3:35 - 4:00 PM
6.	Evaluation/Technical Assistance Vote-Principles for Capacity Bldg/Tech Assistant Vote-Principles for Strategic Plan for Evaluation	Mike Allison/Roberto Garcia/Ellen Goldstein	4:00 - 4:30 PM
7.	Break		4:30 - 4:40 PM
8.	Epi/Research Vote - Research Priorities	Patrick Forte	4:40 - 5:05 PM
9.	Linkages Concept Vote - Recommendations for Referrals	Edward Zold/Chata	5:05 - 5:25 PM
10.	Process Evaluation Report	Kathleen Roe	5:25 - 5:45 PM
11.	Activity Based RFP	Valerie Kegebein	5:45 - 5:55 PM
12.	Meeting Evaluation	Chata	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - September 12, 1996, 3-6 PM, First Unitarian Church, 1187 Franklin Street, San Francisco.

DPH

HIV PREVENTION PLANNING COUNCIL
MINUTES
August 22, 1996

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Members Present:
Chata (Ronnie Ashley)
Isabel Auerbach
Dale Frett
Roberto Garcia
Ellen Goldstein
Natalie Gutierrez
Liz Highleyman
Valerie Kegebein
Sacul L'Adnbre
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Bethsaida Ruiz
Gregory Walker

Members Absent:
Barbara Adler
Hector Carrillo
Christine Edwards
Patrick Forte
Tony Hall
Piper Hyland
Marvin Lee
Ramon Martinez
Terry Ryan
Sandy Simms
Zwazzi Sowö
Joshua Tager
Joshua Volle
Edward Zold

AIDS Office Staff:
Kristen Clements
Brian Dobrow
Delia Garcia
Marshia Herring
Norm Nickens
Tracey Packer
Billy Pick

Evaluation Team:
Cindy Berenstein
Christina Goette
Kathleen Roe
Kevin Roe

Consultants:
Mike Allison, The Support Center
Mary Irvine, Polaris, Inc.
Lyn Paleo, Harder + Co.
Eden Tanovitz, Harder + Co.

Guests:
Bartholomew T. Casimir, American College of Traditional Chinese Medicine (ACTCM)
Elizabeth Davis, STD/HIV Prevention and Control Program
Lani Ka'ahumanu, Coalition on Bisexuality and HIV Education and Prevention (B-HEP)
Charlotte Kent, STD/HIV Prevention and Control Program
Cameron Lee, ACT UP/Golden Gate

1. WELCOME & INTRODUCTIONS

The co-chairs welcomed all present, and announced that there was not yet a quorum for decisionmaking. Because of the lack of a quorum, agenda items had to addressed out of order. Those in attendance introduced themselves around the room.

2. ANNOUNCEMENTS

- Chata announced that the Steering Committee convenes on Friday, September 6th, from 9-11:30am, to put together the document on roles and responsibilities in the planning process. Members of the Council are invited to attend this meeting, and/or to fax any recommendations they may have to Ana Claire, Valerie, and Chata at the AIDS Office (Fax:

431-7547). The co-chairs will work on a draft to bring to the Steering Committee, which will then revise the draft for presentation to the full Council. This document will also be submitted to Sandra Hernandez, Gene Copello, and Mitch Katz. They will be able to review the roles and responsibilities before attending a Council meeting.

- Tracey thanked the Council for the baby shower that was held for her at the last Council meeting (August 8th). She informed the group that she would be going on maternity leave starting on September 13th, until the end of January.

3. PUBLIC COMMENT

No public comments were offered at this meeting.

4. ACTIVITY-BASED RFP

Valerie noted that the proposals for the behavioral risk populations had been due on Monday, August 19. The AIDS Office had received those proposals, and review panels were to meet on Monday and Tuesday (August 26th and 27th). Valerie said that the AIDS Office had held an orientation for the review panelists. Once the review process is completed, the AIDS Office will send out award letters to the agencies to be funded through this round of proposals. In response to a question about who had been chosen as review panelists for the first RFP, Valerie explained that the identity of the review panelists is kept confidential (as a protection against possible attempts to influence the panelists' decisions) until after the review and technical report are complete.

Regarding the activity-based RFP, Valerie said that she had heard the Council's concerns, about the need to receive some information in advance of the RFP release. Since the activity-based RFP had already been published, it could be discussed to some extent at this opportunity. The RFP would be released on Friday, August 23rd, at 8:00am. Valerie added that this RFP includes CDC, California State, and General funds. She then listed the interventions included in the RFP:

1) Venue-based Individual Outreach (VBIO), for which **a collaboration or an individual agency can apply** to provide services in those particular areas of the city in which populations at high risk for HIV can be found. Valerie stressed that providers may apply for this funding in one of two ways, and that the reviewers and AIDS Office will have to make the final decisions about which proposals are strongest and which seem to offer the best coverage of the city. This intervention will be expected to address behavioral risk populations (BRPs) 1-12, with special emphasis on 1-7.

   For collaborations, the proposal reviewers will (using the information in the Linkages Study and the Council-approved recommendations from the Linkages Committee) look at the mechanisms for oversight and structure of the collaboration. If individual agencies are selected to provide this service, they will be required to participate in an AIDS Office-sponsored consortium of VBIO providers.

   Valerie added that the AIDS Office would be establishing a standard cost per unit of service for this intervention. Jimmy spoke up to say that a decision to go with the lowest cost per unit of service would not necessarily produce the best services or the best coverage of the city. Valerie responded that this concern would be taken into account.

2) CTRPN (anonymous and confidential), for which any and all BRPs can be proposed. Valerie noted that the State of California only gives a set amount of money ($436,560), and that it must be used for a certain structure of CTRPN services. If CDC and General funds are used for this intervention, then the program and the AIDS Office will enjoy greater flexibility of design.

3) Provider Training, for which providers (not BRPs) are the target group. This prevention activity is designed and funded as a means of keeping the pool of prevention providers up-to-date and in compliance with the San Francisco HIV Prevention Plan.

4) General Education, for which proposals may address all twelve BRPs, including those at lower risk. This activity includes the city condom distribution campaign, which is limited to gay-identified venues and to $15,000 in funding (including staff time and condom purchasing costs), but which does not prevent other providers from distributing condoms.

Sole-sourced Contracts
Under General Education, the Hotline will be sole-sourced to the current provider (San Francisco AIDS Foundation), who will be required to write a proposal for review. This represents a decision made by the AIDS Office. The DPH programs are all being maintained at their current levels, but they also have to write proposal narratives (with scopes of work, etc.), as if they were responding to an RFP.

5. BREAK
With the hope of achieving a quorum (necessary for all other agenda items for this meeting), the co-chairs asked members to take an early break. During the break, the co-chairs realized that the fourteen members present at this point in the meeting would constitute a quorum, since the total membership is currently 28, and Sandy Simms (of the State Office of AIDS) should not be counted for a quorum (it is already understood that she cannot attend the majority of Council meetings). This left a ratio of 14/27, which meets the quorum requirement (more than half of the members).

6. APPROVAL OF MINUTES FROM AUGUST 8TH AND JULY 25TH (THE RETREAT)
August 8th
Jimmy said that he would like to add to the minutes (on p. 11) that he asked how much money was left for the Delta Study, and that there was no response to the question. With this addition, the minutes of August 8th were approved.

July 25th
The Council Retreat minutes were approved without exception.

7. GOALS & OBJECTIVES & FUTURE DIRECTIONS COMMITTEE PRESENTATION
Tracey Packer explained that she would be making this presentation for Committee Chair Barbara Adler, whose severe back pain had prevented her from coming to this meeting.

Vote -- Goals and Objectives for the 1997 CDC Application
Tracey explained that the 8/21 draft of this document, distributed at this meeting, reflected the feedback offered previously by the Council. She said that the accuracy of the estimate for the rate of new infections (150/100,000) was currently being researched at the AIDS Office. Kristen offered the following clarification: The incidence rate (150/100,000) shown in this document was drawn from the 1992 local Consensus Report (for which a group of epidemiologists came together

to discuss and agree upon HIV-related estimates). The Consensus Report included children, and is now four years out of date. However, it will probably have to stand as the source for this estimate, until a similar (but more recent) source becomes available. Kristen suggested that the objectives mentioning this estimate should reflect the year (1992, not 1995) that it was produced. Tracey agreed to make this change.

Tracey informed the Council that, since the last Council meeting, Process Objective #3 had been added (based on input from Valerie). She also reported that the BRP process objectives would be expanded to account for all interventions receiving CDC funding (not, as the draft suggests, all interventions funded with all sources).

With no further questions on the floor, the motion was made to approve the "Goals and Objectives for the 1997 Application to the CDC" (with the understanding that the incidence rate will be shown as the 1992 estimate, and that BRP process objectives will be written for all CDC-funded interventions).

The Vote	
In Favor:	**13**
Opposed:	**0**
Abstentions:	**1**

The motion to approve this document passed by consensus.

Concept Vote -- Goals and Objectives for the 1997 HPPC

Tracey opened by noting that this document (also distributed in its 8/21 draft form at this meeting) would reflect the change, regarding the 1992 rate, that Kristen had suggested. She pointed out that this document includes more specific impact objectives than the document for the CDC application. Tracey also explained that the committees which will be assigned the specific tasks shown in the process objectives cannot be named for 1997 at this time. However, when the names of the 1997 committees are known, they will be inserted into the appropriate process objectives for this document. The process objectives were formulated with input from the committee chairs and the Council co-chairs on the tasks for next year. Finally, Tracey noted that the committee, with assistance from the Linkages Committee, still has to define "successful referral" for the document.

Discussion

Jimmy asked why the document only refers to AIDS Office-funded prevention providers. He said that CDC direct-funded providers would also be asked by the CDC to comply with the HPPC guidelines. He added that, as a general rule, all of the San Francisco prevention providers should be expected to uphold the HIV Prevention Plan. Tracey responded that she agrees in principle that all San Francisco prevention providers should comply with the Plan, regardless of their funding source. However, the AIDS Office will not have jurisdiction over agencies not receiving AIDS Office funding next year. She said that, while a link has not yet been clearly established with CDC direct-funded providers, their compliance should follow that of the AIDS Office providers (and will precede the general compliance of all San Francisco providers).

Liz asked a question closely related to Jimmy's question above. She wondered whether the third process objective on the last page of the document would only apply to research funded by the AIDS Office. Tracey responded that the Council would want to be connected to all local research, but that it only has specific jurisdiction over the AIDS Office-funded projects. She said that the

HPPC and AIDS Office would strive to influence other local prevention research as well, however. Lyn added that the committee might want to re-word the objective mentioned by Liz, because the committee will not just be "monitoring" the progress of studies, but will be keeping abreast of research underway. Tracey requested that the Epidemiology & Research and the Evaluation & TA Committees look at this research-related objective, and provide feedback to the Goals & Objectives Committee on how to revise it.

Mark asked what the committee had meant by its statement that referrals will be given "based on assessment and/or request." Tracey responded that the committee still needed to clarify this point, and would work on that objective at the committee meeting to be held the following morning.

Ellen noted that the impact objectives seemed to have been written for different levels and sites of responsibility, without clear separation according to which party would be responsible for the completion of which objective. She suggested that the objectives could be reorganized in such a way as to identify clearly who will be expected to complete each one.

Ana Claire asked that the committee add a phrase about the need to look at "incentives for participation" on the Council, to the second-to-last objective on the first page of process objectives.

Jimmy questioned the dates of completion assigned to some of the committee tasks in the process objectives. Specifically, he thought that 3/31/97 was too early a date for the fulfillment of the three tasks related to resource allocation and resource inventory.

Lyn noted that the second process objective on the final page of the document refers to the work of two very different committees, with two separate concepts. She also said that the revision of the Epi.-Profile is only now beginning in the Epidemiology & Research Committee, so that the chapter will probably not require another revision next year. Liz asked whether the Epi.-Profile and the research priorities were supposed to be updated each year. Tracey responded that these tasks do not have to begin anew each year, but that the Council will need to consider how often it does expect the chapter and the research priorities to be updated. For the research priorities, the HPPC should not have to repeat the full process in which the Epidemiology & Research Committee engaged this year -- but some of the priorities may need to be expanded and/or shifted from year to year. Valerie added that, as some of the original priorities are met, the list will need to be updated.

With no further questions on the floor, a motion was made to approve, in concept, the draft "Goals and Objectives for the 1997 HPPC," with the understanding that the issues mentioned above will be addressed by the committee before the final vote on this document.

The Concept Vote	
In Favor:	**14**
Opposed:	**0**
Abstentions:	**0**

The motion was passed unanimously.

8. EVALUATION & TECHNICAL ASSISTANCE COMMITTEE PRESENTATION
Vote -- Principles for Capacity-Building/Technical Assistance
Committee Chair Roberto explained that this committee had met on Tuesday, and had received a final report from Mike Allison on the findings of the Organizational Development/Technical

Assistance (OD/TA) team. At the end of this presentation, the written report (enclosed for those absent) was made available to everyone present. Roberto read over the "Key Findings and TA Implications from Capacity Assessment" document, which was attached to the principles to receive a Council vote (full handout enclosed for those absent). He explained that the Council would be asked to approve the principles for TA provision, in line with the philosophy of the five-year strategic evaluation plan, and the principles for the different levels of evaluation. Roberto introduced Mike Allison, who had come to the meeting to answer questions about OD/TA issues.

Mike explained that the assessment had functioned as a first opportunity to talk with such a large number and wide range of agencies about what they need to move toward implementing the HPPC recommendations. He reported that the OD/TA team would be developing individual TA contracts with each AIDS Office-funded agency. Mike noted that the general enthusiasm of the agencies about the prospect of TA support had in turn inspired enthusiasm in the TA providers.

Ellen, an Evaluation & TA Committee member, pointed out that the full report can be instructive for agencies considering future TA possibilities and objectives, and/or wanting to look at where they fit into the spectrum of providers, with regard to strengths and weaknesses in the capacity areas. She said that the report clearly conveys the range, and the particular highs and lows, of capacity levels among prevention agencies.

Discussion

Mark asked what was meant by "client satisfaction," in the fifth principle for TA resource allocation. Mike responded that the client, in this case, would be the prevention agency receiving the TA. Isabel asked what would determine the "highest priorities," mentioned in the third principle for TA provision. Mike answered that the highest priorities would be those established by the particular agency and identified in the individual assessment report on that agency. Ellen added that the TA would be designed to move the providers along on the continuum of capacity, and that the highest TA priorities would relate to the obstacles to progress along that continuum. The Council agreed that the next draft of TA principles should provide clarity on these two terms.

Ana Claire asked what had happened with the four agencies that had not been able to participate in the needs assessment process (as of the last OD/TA report to the Council). Mike replied that two of those agencies had been undergoing a large transition, and that the other two agencies had just been overburdened and unable to make time for the assessment. The OD/TA team had invested significant time in the effort to gain cooperation from these four agencies, but had not been able to get a response. Mike explained that the team would still try to extend TA to these non-participants in the assessment, and would attempt to do abbreviated assessments of those agencies, as a basis for the TA provision. Ana Claire asked whether the team would conduct repeated mini-assessments, in order to continue to identify TA priorities. Mike responded that, while the committee had not yet discussed this particular issue, the TA would probably continue to be updated and re-prioritized over time.

Jimmy asked why a program with insufficient capacity or capability would even be funded at all. He said that he understood the need for some commonality between all of the providers funded, but that he couldn't see the point of starting from ground zero with TA provision. In short, he wondered how the TA would fit into the two-year or three-year plan for evaluation. Ellen pointed out that, even an agency strong in the area of providing client services may have weaknesses in some of the capacity areas assessed (e.g., intra-agency communication), and may benefit from TA. Kristen added that the committee believes in the idea of leveling the playing field, and setting

realistic objectives for providers. If, in the future, some of the TA recipients are still not meeting the capacity objectives, then the Council will need to examine whether to keep giving them support. Kristen summarized that the committee has been grappling with how many mini-assessments to do and when to expect that TA-supported agencies will be making progress toward their objectives. She added that the committee had agreed that mini-assessments would be conducted with any newly AIDS Office-funded prevention agencies, before those agencies receive specific TA.

With no further questions on the floor, a motion was made to approve (with the clarifications requested above) the "Principles for Allocation of TA Resources."

The Vote	
In Favor:	**14**
Opposed:	**0**
Abstentions:	**0**

The motion was passed unanimously.

Vote -- Principles for Strategic Evaluation Plan

Ellen called the attention of members to the second sheet of the handout, titled: "Evaluation Principles Guiding Strategic Evaluation Plan Objectives." She briefly explained the principles behind each of the four levels of evaluation -- provider level, community level, experimental/quasi-experimental, and HPPC/AIDS Office support for evaluation.

Discussion

Chata asked whether the committee had set minimum standards (see principle #6 under "Provider Level"). Ellen responded that, for the first year of provider level evaluation, the minimum standards had been set and approved by the Council -- in the form of the requirements for the behavioral risk assessment. The committee will continue to raise evaluation standards over time. Kristen noted that the committee might want to use the term "minimum expectations," and to explain that these expectations will gradually increase as providers' capacity levels are raised.

Jimmy expressed his concern that, regardless of whether providers produce the data in compliance with the Plan, there would not be an opportunity for centralized analysis and comparison of the data across agencies. Ellen responded that, because of the requirement for use of standardized variables, the behavioral risk assessment will mark the first opportunity for comparison of agency level behavioral data. She added that the committee has been working on recommendations to ensure that the data is used by the collecting agencies. The committee is still working on the question of how to offer support for data analysis (i.e., ensuring that all agencies are provided with the skills and software necessary to perform their own analysis, or providing consultant support to assist agencies with the process of analysis). Ana Claire noted that the Evaluation/TA Committee could make a recommendation on data use, for incorporation into the goals and objectives.

With no further questions on the floor, the motion was made to approve the evaluation principles.

The Vote	
In Favor:	**13**
Opposed:	**0**
Abstentions:	**0**

The motion was passed unanimously.

Kristen informed the Council that the committee had begun by drafting the objectives for each year and each level of evaluation, and had then realized the need to backtrack to the principles behind the evaluation plan. She said that the committee would now return to the former task, which should tie in more closely with the work of the Goals & Objectives Committee.

9. EPIDEMIOLOGY AND RESEARCH COMMITTEE PRESENTATION
Vote -- Research Priorities

Liz presented for this committee, since Committee Chair Patrick Forte had been unable to attend the most recent meeting. As she spoke, she referred to the 8/20 committee document that had been faxed to the Council membership prior to this meeting. She briefly described the committee's process for determining research priorities. It began with a series of key informant interview panels, organized to provide some insights into populations which the committee had identified as groups for which little data exists. The committee then began to use and refine a set of criteria for prioritization and a list of basic study types.

Under the five study types -- Prevalence/Incidence, Basic Risk Behavior, Advanced Risk Behavior/Psychosocial, Formative, and Other -- the committee began to arrange populations that it had brainstormed as underresearched groups at risk for HIV. Each study type has slightly different criteria, which were used to determine whether a given population should be prioritized for investigation with that type of study. Through the application of the criteria and the consideration of additional issues for prioritization (articulated on p. 5 of the 8/20 summary document), the proposed studies were ranked within each study type. Liz informed the Council that the committee had felt strongly about all of the studies remaining in the final list; all of them were seen as priorities. For this reason, the three ranking levels were referred to as "priority, high priority, and very high priority." The items shown under "Other Studies" were not ranked, because they were understood to be outside of the purview of this committee and of the Council. However, the committee agreed that it would be important to recommend these studies to other researchers and funding sources.

The committee took an additional vote at the end of its prioritization process, in order to determine its top two recommended studies. The studies chosen were: (1) a prevalence study of Asian and Pacific Islander MSMs (for whom there is a lack of prevalence data, which tends to function as a prerequisite for other, more advanced kinds of research projects) and (2) an advanced risk behavior/psychosocial study of African-American MSMs (to learn what factors drive the unusually high prevalence rate for this population, which has reported risk behaviors at similar levels to those reported by other MSMs). The other three studies ranked in the highest priority group include:

- an advanced risk behavior/psychosocial study of **MSMs using speed and/or poppers** (oversampling ages ≤ 26) -- looking also at issues of migration, initiation sex, and recent arrival in San Francisco
- a prevalence study of **homeless (male and female) youth** (≤ 26) in all BRPs -- looking also at involvement in the sex trade and substance use
- a formative study of **migrant workers** (male and female) in all BRPs -- looking also at migration and immigration

Liz noted that, for all of the prevalence studies, the committee had recommended the collection of basic risk behavior variables.

Discussion

Chata said that the committee might want to consider adding a prevalence study of Native Americans. Liz responded that the committee had considered a prevalence study, but had found that it didn't fulfill the criteria. However, the committee did recommend a basic risk behavior study of Native Americans, in the high priority category.

To make sure that the committee had complete information on the research available for the recommended study populations, Ellen mentioned a current qualitative interview study (being conducted at CAPS, with SFAF funding) of gay men and methamphetamine use. She also mentioned Los Angeles KABB studies of homeless youth. Kristen noted that these KABB studies had not collected any street-based prevalence data, which was what the committee hoped to gain from its recommended study for homeless youth. Ellen closed by mentioning a recently published book, by Shirim Mishra (sp?), on migrant workers and HIV; she thought that the book might add to the committee's deliberations.

Jimmy asked about the overlap between the populations to be sampled for the two recommended prevalence studies with Asians and Pacific Islanders; he wondered how the committee had decided to place one of these studies at the highest priority level, and the other at the high priority level. Lyn responded that, while there is overlap, one of the studies will look at all A/PI groups of males having sex with males (BRPs 1, 2, 4, and 5), and the other will look at all A/PI IDU groups (BRPs 1, 2, 3, 7, 8, and 9). Jimmy then made the point that the category, "Asian and Pacific Islander," accounts for a large and very diverse group of populations. He said that, while little research has been done with Asians and even less has been done with Pacific Islanders, he would like to see more focus than the category, "Asian and Pacific Islander," suggests. Liz responded that the committee had addressed this issue internally. Members had initially defined Pacific Islanders as a priority population for research, and had later raised concerns about the lack of prevalence data on Asians, as well as on Pacific Islanders. However, they agreed that the different cultural groups within the general A/PI sample should be broken out as clearly as possible in the process of data collection. Kristen added that the committee had recommended the oversampling of Pacific Islanders, in order to ensure that the data collected on this group will have statistical significance.

Jimmy also commented that he didn't see much being prioritized for younger people, despite the trend in the last several years toward higher rates of infection among youth. Liz noted that a recommendation to oversample youth could be added to the lists of prioritized studies.

Ana Claire asked for more explanation of the committee's decision to drop the idea of a prevalence study for Native Americans. Liz explained that the criteria had been applied, and members had still had questions about the appropriateness of a prevalence study. (Specifically, the first, third, and ninth criteria for a prevalence study had not been positively met. Members were aware of some prevalence data on Native Americans, but identified a clear lack of basic behavioral data.) Kristen added that the existence of a good basic risk behavior study for Native Americans would increase the likelihood that funding could later be obtained for a prevalence study (which would be more expensive than the basic risk behavior study). The risk behavior study would also demonstrate whether the size of this population is large enough in San Francisco to do a San Francisco-based prevalence study of Native Americans.

Ana Claire remarked that it would help the Council to have some documentation of the committee's discussion of these issues. An understanding of the committee's full process would also assist future Councils with the task of setting research priorities. Kristen responded that the committee's decisionmaking process was well-documented in the minutes, which could be summarized for the Council in the form of tables, showing the studies proposed and the results of the application of the prioritization criteria.

Bethsaida asked why transgendered status had been put in the column for covariates. Liz explained that, while transgendered persons are included in the general BRPs 1-12, the issues specific to the transgendered community could not be examined effectively through an unlimited sampling of the general population of San Francisco. For this reason, the committee had decided only to sample transgendered persons for this prevalence study. Transgender identity was seen as the defining factor for this study population. Lyn suggested that the description, "Transgender," could be moved into the left side of the column for BRPs, in order to define the focus as transgendered persons in all twelve of the behavioral risk populations. The Council expressed support for this change.

Isabel asked what exactly the committee had meant in stating, "Every effort should be made to obtain funding for these two top prioritized studies." Kristen responded that, in the past, the community planning process has not driven the funding process of funding sources. The Epidemiology & Research Committee decided to approach the funders **proactively** with recommendations for future research projects, with the hope that these recommendations might influence the prevention research RFPs to be issued. The committee agreed that the AIDS Office should take existing funding opportunities to conduct any of the listed studies. For the top two studies, the committee expects that the AIDS Office will use every possible channel to get notice for these priorities and to secure funding for them.

Isabel then asked for an explanation of the population being described as "migrant workers." She said that she thinks of migrant workers as living in rural environments, and not in San Francisco. Liz explained that Vic Hernandez (a community member on the committee), who works with populations of migrant workers, has made it very clear that day laborers also spend time in cities. Many migrant workers perform agricultural work in the summers, and return to the cities in the winter, where they may end up doing sex work to survive. Vic had stressed the need to examine the connections between these patterns of seasonal migration and patterns of access, of behavior, and of infection.

Isabel asked whether the studies had been ordered by their scorings within each priority level. Liz noted that, for example, the "high priority" (middle group) studies had been given very close scores. The committee had not wanted to overemphasize a difference of one or two points in either direction, when there were such clear clusters of studies in the three ranking levels. The Council would not be asked to vote on the actual scores, or on the ranked order of studies within each level of priority.

Isabel raised a concern about the relatively few prioritized studies for female populations. Liz responded that this had been a difficult issue, because women do tend to fall into the lower-ranked BRPs (from the 1995 Priority-Setting model). (One of the criteria for prioritization, across study types, relates to evidence of elevated risk for infection.) However, female samples are included in the very high priority studies for homeless youth and for migrant workers. They are also included in six of the eight high priority studies and in two of the four priority studies.

Roberto asked about the choice of poppers as a co-factor for research; he explained that he would expect alcohol to have a greater influence than poppers on risk behavior. Lyn explained that the substance use research cited in the Priority-Setting Chapter of the Plan indicates a greater relationship between risk-taking and popper use. Liz added that the committee had begun with a proposed study for MSMs (BRPs 1, 2, 4, and 5) and speed use; poppers had been added later, when two proposed studies were combined.

Kristen informed the Council that the two studies chosen by the committee as deserving the top priority had stood out (both in discussion and in their actual scorings) clearly above the rest.

The motion was made to approve the listed studies in the three levels of priority, and the top two urgently recommended studies, with the following amendments:

- Pacific Islanders will be oversampled in the two prevalence studies recommended for A/PIs.
- Youth will be oversampled in general, for those studies that were not specifically recommended to address a lack of data on older populations.
- The modifier, "Transgender," will be moved to the left of the column for BRPs to be studied, so that it reads: "Transgendered persons in all behavior groups."

Further Discussion

Some discussion followed the motion. Isabel said that, if more time had been allowed for this agenda item, she would have liked to hear about the issues raised in the application of the **ethical** criteria for prioritization. She anticipated some ethical issues for the studies included in the list of recommendations, and wondered what would be required for a study not to fulfill the committee's criteria for ethical acceptability. Lyn explained that no extensive record was kept of the discussions of the applicability of the criteria to the proposed studies. Tables were made to document whether the committee had viewed each criterion as being met (+), unmet (-), or unclearly met (+/- or ?) for each study. The committee process was complicated, and had to move quickly, in order to satisfy the timeline for these recommendations.

Roberto asked for more clarification on whether "migrant workers" were being defined as agricultural workers or not. (He was wondering, in part, whether the book Ellen had mentioned might answer some of the research questions of the committee). Liz explained that the committee's definition was not exclusive to urban or rural migrant workers. For example, the committee would include laborers moving seasonally between rural areas and urban centers.

The Vote

In Favor:	**13**
Opposed:	**0**
Abstentions:	**0**

The motion was passed unanimously.

10. LINKAGES COMMITTEE PRESENTATION

Concept Vote -- Recommendations for Referrals and Linkages

Chata read a summary explaining (1) the sources used in the committee's process of forming recommendations on linkages and referrals, (2) the categories of recommendations (and subdivisions indicating the parties responsible), (3) the inclusion of both shorter-term and longer-

term recommendations, and (4) the committee's approach to ensuring a continuum of care for those in need of services. (The notes from which Chata read are enclosed for all members.) A draft of the recommendations for referrals and linkages was distributed at this meeting, for a concept vote.

Discussion

Ellen asked what the committee had meant by suggesting that client-centered counseling creates a barrier for referral (under #4 *HPPC*, p. 3 of the document). Chata explained that this concern had emerged in the Harder + Co. interviews with providers. Tracey said that the barrier might have to do with a misinterpretation of the client-centered model, or might actually have to do with the model itself. Providers expressed the concern that, when the client lacks awareness and education about the resources available, the client-centered model prevents the provider from making a referral (since it has not occurred to the client to request one).

Roberto asked about the recommendation for use of standardized forms for documenting referrals (under #3a. ii., on p. 2), and whether this would address Jimmy's point about the need for centralized analysis. Eden responded that the committee had made this recommendation in order to allow for the analysis of referral outcomes in relation to demographic variables, risk factors, and intervention types. (**Note:** The committee has since changed the language of this recommendation, so that it does not suggest that the forms will create a "link" between referral data and the data from the behavioral risk assessment. Demographic and basic risk behavior variables will have to be collected separately in the referral process, since the behavioral risk assessment will not be conducted with all clients.) Mark added that the standardized referral data would allow for the recognition of any service gaps for a particular population or any patterns of, for example, non-completion of referrals due to the inappropriateness of the referrals given. Roberto noted that the committee should look closely into issues around confidentiality, and into ways of exchanging client information (between providers referring to one another).

Charlotte Kent, a community member on the Epidemiology & Research Committee, raised a question about the recommendation for stronger relationships between CTRPN providers in particular. The co-chairs identified a procedural issue, in that community members are not supposed to speak outside of the public comment section of the meeting. Because the discussion was structured as a time for Council members only to speak, Charlotte's question could not be answered. Having heard the comment, Tracey indicated that Charlotte's input would be considered. (**Note:** The committee has since addressed Charlotte's question, and has made some changes to the recommendations to clarify the kinds of referral relationships being encouraged.)

Roberto asked that the committee clarify its language around agencies "working together." He said that contractual collaborations need to be defined and discussed differently from informal collaborations or memorandums of understanding between providers.

With no further questions on the floor, the motion was made to approve, in concept, the draft "Recommendations for Referrals and Linkages."

The Vote	
In Favor:	**13**
Opposed:	**0**
Abstentions:	**0**

The motion was passed unanimously. Following the vote, Roberto asked if there is a study measuring how the existing AIDS Office-funded collaborations have been working. Chata responded that AIDS Office staff (Tracey Packer and Judith Klain, both on the Linkages Committee) had performed an evaluation of the existing San Francisco collaborations, and a report had been furnished to the committee, for the development of the recommendations on collaborations (approved by the Council earlier this year).

11. PROCESS EVALUATION REPORT

Explanation of Summary Documents

Kathleen Roe explained that four new summary documents were being distributed by the Evaluation Team at this meeting:

1) "1996 HPPC Process Objectives: Progress to Date;"
2) "HPPC 1996 Log" of basic accomplishments of HPPC and committee meetings to date;
3) "Summer Committee Work: Activities since June 13 HPPC Meeting," outlining recent committee accomplishments, current tasks, and upcoming meetings; and
4) "Themes at Midyear," a sensitizing document drawn from a variety of sources of testimony from Council members

These documents were identified as Council needs, at the July 11th HPPC meeting. The Evaluation Team had offered its support to remind Council members of progress on tasks and of decisions made during the planning process.

Regarding the Log, Kathleen noted that:

- the co-chairs will fill in their notes for the co-chairs meetings that took place before Kathleen began attending them;
- April 25th marked the first set of HPPC votes this year (see the bolded, italicized text);
- a new page will be added as an update, at each HPPC meeting; and
- the Evaluation Team will make any additions or changes suggested by Council members (if they remember something happening differently from what appears in the current Log).

Regarding the "Themes at Midyear" document, Kathleen told the Council that Charles had been powerfully moved by the experience of conducting the Council member phone interviews during the spring. He found that the interview respondents were able to express concerns that were generally not expressed in the full Council setting. These perspectives were incorporated into the "Themes at Midyear" sensitizing document, which conveys some of the emotional/thought processes and the group dynamics accompanying the planning process. Kathleen requested that Council members examine the points in this one-page summary document, and keep them in mind while participating on the Council. She added that, regretfully, several of the members who contributed the fullest, most informative interviews with Charles have since left the Council.

Support to Committees

Kathleen added that the Process Evaluation Team can be called upon to assist with the accomplishment of committee tasks. For example, the Goals and Objectives Committee used the resources of the Evaluation Team, in order to put together the "Goals and Objectives for the 1997 HPPC" document for this meeting.

Evaluation Team Announcements

- Paul and Charles have both left the Evaluation Team for other pursuits.

° The Evaluation Team will continue to attend some (though not as many) committee meetings, for long-term observations.

Different Role of Evaluators on Steering Committee and in Co-Chairs Meetings
Kathleen told the Council that the Evaluation Team members do participate in the Steering Committee and the co-chairs meetings in an active capacity. They interact differently at those meetings, where they function to the best of their ability as the voice of the Council (drawing upon comments made in interviews, meetings, evaluation forms, etc.). The evaluators try to stay true to the voices heard from the Council, rather than massaging or redirecting the information. They are able to take on a more personal, involved role -- rather than simply sitting in as observers (which is how most Council members have seen them).

Request to Sit with Members
Kathleen made a request to sit at the table alongside the members, in order to play a more integrated and informative role, when appropriate. This way, she would be able to refer to the data collected by the Evaluation Team, when this data relates to the discussion. She added that, in the past, she had not wanted to interfere with the Council process by sitting at the table. However, at this point, she feels that the Evaluation Team has more experience, information, and perspective to contribute to the process. The Council welcomed Kathleen to the table.

Additional Support to Council
Finally, Kathleen asked that the Council feel free to utilize the resources of the Evaluation Team. She said that the evaluators could assist with process issues or documentation, and that they could always refuse any requests that go beyond the scope of their work. Ellen asked if the Evaluation Team could work on possible alternative processes to Robert's Rules. Kathleen responded that Cindy would probably be able to help with this task, since she has had experience with other planning councils. The Steering Committee had also put this issue on its next meeting agenda.

Enclosed with These Minutes (for all members):
- "Recommendations for Referrals and Linkages: Linkages Committee Report..." -- 8/22 notes
- **Revised** draft document for the 9/12 vote: "Recommendations for Referrals and Linkages"
- **Revised** draft document for the 9/12 vote: "Goals and Objectives for the 1997 HPPC"
- Updated September calendar of HPPC and related committee meetings

Enclosed with These Minutes (for those absent):
- Draft Goals and Objectives for the 1997 CDC Application, and for the 1997 HPPC
- "Status Report: OD/TA Project" document, with principles for TA and levels of evaluation
- "OD/TA Project Status Report 8/20/96" document, summarizing the assessment results
- "Recommendations for Referrals and Linkages -- Draft for Concept Vote"
- "1996 HPPC Process Objectives: Progress to Date"
- "HPPC 1996 Log"
- "Summer Committee Work: Activities since June 13 HPPC Meeting"
- "Themes at Midyear"
- 8/8/96 "Evaluation Results" and "Participant Dialogue" boxes
- Group letter of protest of the RFP (No. 015-96), to the AIDS Office (Dr. Mitch Katz)

Next Meeting: Thursday, September 12th, 3-6pm at the First Unitarian Church (1187 Franklin)

Minutes Recorded by: Mary Irvine
Minutes Approved by: Co-Chair Valerie Kegebein (Feedback was not received from the other co-chairs.)

HIV PREVENTION PLANNING COUNCIL MEETING

September 12, 1996
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

Please read: Agenda, minutes of August 22 and committee minutes

***Please bring*:** Entire package, and applicable committee meeting minutes

Agenda

1.	Welcome & Introductions	Ana Claire Meyer	3:00 - 3:05 PM
2.	Minutes from August 22	Ana Claire Meyer	3:05 - 3:10 PM
3.	Announcements: Steering Committee Report Status Report on RFP	Ana Claire Meyer	3:10 - 3:20 PM
4.	Public Comment	Ana Claire Meyer	3:20 - 3:40 PM
5.	Goals & Objectives - Vote	Barbara Adler	3:40 - 4:00 PM
6.	Break		4:00 - 4:10 PM
7.	Council Issues About RFP	Lyn Paleo/Kathleen Roe	4:10 - 5:00 PM
8.	CDC Application - Discussion & Possible Vote	Brian Dobrow/Ana Claire Meyer	5:00 - 5:45 PM
9.	Delta Project Update	Delta Staff	5:45 - 5:50 PM
10.	Meeting Evaluation	Ana Claire Meyer	5:50 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - September 26, 1996, 3-6 PM, First Unitarian Church, 1187 Franklin Street, San Francisco.

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HIV PREVENTION PLANNING COUNCIL
MINUTES
September 12, 1996

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Members Present:
Barbara Adler
Ronnie Ashley
Isabel Auerbach
Patrick Forte
Roberto Garcia
Ellen Goldstein
Natalie Gutierrez
Liz Highleyman
Piper Hyland
Sacul L'Adnbre
Ana Claire Meyer
Jimmy Naritomi
Mark Peppler
Joshua Volle

AIDS Office Staff:
Irene Carmona
Kristen Clements
Brian Dobrow
Tracey Packer
Mike Pendo

Polaris, Inc./Harder + Co.:
Mary Irvine, Polaris
Lyn Paleo, Harder + Co.
Eden Tanovitz, Harder + Co.

Process Evaluation Team:
Cindy Berenstein
Kathleen Roe
Kevin Roe

Members Absent:
Hector Carrillo
Christine Edwards
Dale Frett
Tony Hall
Valerie Kegebein
Marvin Lee
Ramon Martinez
Bethsaida Ruiz
Terry Ryan
Zwazzi Sowo
Joshua Tager
Gregory Walker
Edward Zold

Guests:
Kathy Bailey, Westside Women's HIV Prev. Project
Priscilla Gunn, prevention services consumer
Dave Hubbard, State Office of AIDS
Marjorie Katz, RAP
Daniel Mira, community member
Marquita Reyes, Westside Women's HIV Prev. Project
Maria Rinaldi, Instituto Familiar de la Raza
Mitchell Salazar, RAP
Concha Saucedo, Instituto Familiar de la Raza
Lani Schlafman, RAP
Brenda Storey, MNHC
Ann Ueda, LIFE Institute
Michael Washington, Wside Women's HIV Prev. Project
Stephen Zollman, community member

1. WELCOME AND INTRODUCTIONS

Members, guests, AIDS Office staff, and consultants present introduced themselves. The meeting began with a quorum of 14 members, in addition to Dave Hubbard, who sat in for Sandy Simms.

2. MINUTES OF 8/22

The minutes of the last HPPC meeting were approved without exception.

3. ANNOUNCEMENTS

Jimmy

- Ed de la Cruz passed away on Saturday, September 7th. He served as the Executive Director of the West Bay Filipino Multi-Services Corporation, and he was a Filipino activist

for over 25 years. Prior to his direct work with the Filipino community, he was an institutional social worker. The funeral services are open only to family members.

Mark

- The STD Control Program is presenting an "STD Overview" on the 30th and 31st of October. (An informational flyer, distributed at this meeting, is enclosed for those absent.)

Kathleen

- The Evaluation Team distributed three new packets providing updates for the 1996 HPPC log, the committee activities log, and the outcomes of 1996 process objectives, respectively (new pages enclosed for those absent). Kathleen explained that members can simply insert the new pages at the end of the summary documents distributed at the last meeting. The Evaluation Team will continue to produce and distribute updates on these handouts, which document the accomplishments of the Council and its committees.

Liz

- The Stop AIDS Project was holding an evening forum on speed use in the gay community, at 1440 Castro St. (on the night of this meeting).

Ana Claire

- Mayor Willie Brown sent a representative to the September 9th CARE Council meeting, to announce that the mayor reserves the right to appoint all CARE Council members. Those members who have served for more than one year and who still wish to serve on the CARE Council will be expected to re-apply for their positions. The CARE Council has no term limits for its members, so the move may have been made partly in an effort to get some turnover on this planning body. Progress on the regular business of the council will have to be somewhat delayed by the unexpected application and appointment process.

Ann Ueda

- The LIFE Institute is still recruiting for technical assistants to provide support to various community planning councils and to the Ryan White Title II Consortia. (The application form is enclosed for those absent.)
- The LIFE Institute also has an opening for an HIV health care lobbyist now. (Please see the enclosed job announcement.)

Ana Claire -- for the Steering Committee

- The Steering Committee met on September 6th, and made progress on the following items:
  - **Robert's Rules** -- This was a difficult discussion, because the committee was not aware of many alternatives to Robert's Rules. The committee is considering ways in which to make Robert's Rules easier to use, and is looking into the Sturgess Operating Procedure (mentioned by Brian as a possible alternative). The Steering Committee will present its findings to the HPPC in October.
  - **The HPPC meeting agenda** -- which needed to be revised for this meeting, so that the CDC Application and the Council's concerns about the RFP process could be discussed adequately.
  - **The roles and responsibilities of the planning parties** -- on which a new rough draft has been produced by Harder + Co. (draft enclosed for those absent). Lyn used the CDC Guidance and the Bylaws to create a bare-bones document on roles and responsibilities. This document does not incorporate the recent discussions of roles and responsibilities, during which Council members contributed suggestions. Lyn hopes to issue a new draft in October.

Tracey -- Status Report on the RFP

- Proposals for the Behavioral Risk Populations RFP were due on August 19th, and 29 proposals were received. Those proposals reaching the minimum score and including the

basic pieces requested, in the requested format, were sent on to a technical review team of community members without conflict of interest. There has been some delay (due partly to the technical review, on appeal, of one proposal that was originally rejected in the first phase of review). The recommendations for awards would be ready at the end of this week or the beginning of the following week, to go to Dr. Mitch Katz, the director of the AIDS Office.

- Proposals responding to the second (activity-based) RFP are due on September 30th. The technical review should take place on October 17th and 18th.

Ana Claire/Brian

- (In response to a question from Mark, "Is there a way for the Membership Committee to report back to the Council on the departures of old Council members, and their reasons for leaving?" the following clarification was provided:)
  - The departures of John Hamilton, Chandra Pugh, and Jay Seward from the Council were announced at the last Council meeting. John moved out-of-state and Chandra returned to school full-time.
  - A new selection process for HPPC membership is beginning. However, the Selection Committee has not yet been able to proceed, partly because of the unclear status of the CARE Council co-chairs who serve on this committee. The Membership Committee is also in transition, after the departure of its former chair.
  - In early July, HPPC members ought to have received the original letter soliciting nominations. A second letter should have been mailed in the week after Labor Day.
  - At or before the next meeting, the HPPC will receive a more detailed report on the new member solicitations.

4. PUBLIC COMMENT

Mitchell Salazar of RAP talked briefly about the work and the history of the RAP (Real Alternatives Program) in the Mission neighborhood. He said that, on August 19th, the organization had sent Dr. Katz a letter expressing a formal complaint against the first RFP. The RAP also wished to address this Council. Mitchell explained that the RFP has made it difficult to serve women with prevention, "without jumping through 1,000 hoops." He stressed that women, particularly in communities of color, cannot be treated in isolation from children and youth. He briefly described the RAP's success with youth and families and its cost-effectiveness, and said that he was unsure what would happen with this program, in the new resource allocation process.

Dr. Concha Saucedo of IFR (also the Board Chair of RAP) said that the letter had been sent in protest of the "patently discriminatory" procedure of the RFP, which works to the detriment of non-IDU (injection drug-using) women. She said that one might conclude that women, in order to get prevention services, must begin injecting drugs. She said that women had disappeared from the map of the epidemic, because of the weight given to prevalence data in the priority-setting Matrix. Calling the RFP's implications genocidal, she asked the Council to look carefully at RFP #015-96 and future RFPs, in relation to the original intent of the Council. The letter was written as a protest from six different agencies, representing a spectrum of services in San Francisco. As of this meeting (nearly one month later), no response had been received from the AIDS Office. Dr. Saucedo said that she was unsure whether the DPH process had worked against the intent of the Council (and the people of San Francisco). She noted the increasing rates of HIV incidence in different communities of color, and pointed out that such factors had not been accounted for in the Matrix or the RFP process.

Marquita Reyes of Westside Women's HIV Prevention Project spoke about Westside, for which she works as a health educator. She noted that some of the program's clients had also come to this meeting, out of concern about the future of funding for services to women like themselves. She explained that Westside's program teaches women and teenage girls about HIV prevention, and helps them to think well of themselves (to build their self-esteem). These are women whose risk follows from their contact with high-risk partners (partners using drugs, often). Ms. Reyes noted the high rates of infection present among women of color, and said that prevention for women is crucial to achieving the shared goal of HIV prevention in the general population. She said that the time for such prevention services is the present; it does not pay to wait for prevalence figures to prove that women of color are becoming infected at high rates. The Westside Women's HIV Prevention Project provides support for HIV prevention and for dealing with other life issues of importance to the clients. Its staff have seen 250 women and teenage girls since the beginning of this year. Ms. Reyes stressed the importance of this work, and asked the Council to reconsider the need for primary HIV prevention services for women, and particularly women of color. She pointed out the importance of looking at the future, as well as the present, of the epidemic.

Brenda Storey of MNHC said that she understood the work that the Council has done, and the reasons for basing prevention services on epidemiological data and on behavioral risk populations. She noted, however, that not all of the epidemiological data used in the Council's deliberations could be considered current or accurate. For example, she cited an estimate (from the 1994 Plan) that there were 17 HIV-positive Latinas in San Francisco. As a staffperson at an agency providing primary health care to Latinas in San Francisco, she stated that she was certain that there are many more Latinas with HIV in San Francisco, and that a better estimate could be gained through consultation with local clinics serving this population. Of those HIV-positive women she sees at MNHC, she said that the majority are infected through sex with male partners. She challenged the Council to revisit the epidemiological data, and to use the resources of the clinics serving women, for the development of newer, more accurate estimates.

Priscilla Gunn identified herself as a widowed, poor, low-income woman. She explained that she subsists on a General Assistance grant, and already lacks access to many kinds of services. She attends a weekly education and prevention group for women, and credits this group with having helped her stay HIV-negative up to this point. She said that she was not sure whether, without this support, she would be able to keep from getting infected. In closing, she underscored that HIV education and prevention services for women should be a priority, and asked the Council not to allow women to drop out of the picture for prevention funding.

Council Responses to Public Comment

Jimmy thanked the guests for coming forward to address the Council from different community perspectives. From his own perspective, he explained that he felt the HPPC would not have intentionally made a move to exclude women from prevention services. He said that nobody on the Council had known what the second RFP would say, and that now it seemed after the fact, and difficult to see how to fix what happened. Ana Claire added her support to Jimmy's statements.

5. DELTA PROJECT UPDATE

Irene Carmona, speaking for the Delta Project, offered the Council an update on the status of the recruitment, screening, and interview processes of the study. For completed interviews, she gave a breakdown of respondents by their ethnic/racial and sexual identification groups. (A summary handout is enclosed for those absent.)

Discussion
Liz asked where the Delta Project had found the women recruited to participate. Irene responded that flyers had been posted in different San Francisco neighborhoods and venues. The participants are asked where they heard of the study, so that project staff and volunteers can document which respondents are coming from which neighborhoods and venues.

Isabel asked for clarification about whether the full 40 interviews planned would be conducted. Irene explained that the study was still being conducted, and would probably continue until more than 40 interviews had been conducted, to allow for oversampling of certain groups of women.

Ana Claire remarked that she was concerned about the race/ethnicity breakdowns for the 30 interviews completed; they did not seem to reflect the projected makeup of the respondent pool (as presented to the Community Advisory Committee to the Delta Project). She added that the expected number of interviews with HIV-negative participants had already been completed, and wondered whether the project staff/volunteers would continue to expand this sample for the study. Irene responded affirmatively, explaining that the project planned to oversample women of color. Ana Claire asked whether women were being recruited and interviewed in English only. Irene responded that the study was advertising for potential participants in English-language newspapers, and that the surveys were being done in Spanish, English, and Tagalog. The study enlisted the help of CBOs for the recruitment of non-English-speaking groups, and used flyers in Spanish and English. Ana Claire noted that neither the recruitment process nor the survey translation process had been extended to allow for (monolingual or non-English-fluent) Thai, Lao, or Vietnamese-speaking respondents (despite the express request of the Advisory Committee to include these language groups). Roberto expressed his concern about the low respondent rate in certain ethnic groups, and suggested that the project might need to try new strategies for recruiting from those communities. Irene responded that the project had only been recruiting for two and one-half weeks. Roberto commented that this is not a new study, however.

Roberto also asked whether the project was fully staffed at this point. Irene replied that there are no new staff hired to work on the project, but that there are 7 volunteers -- six from the AIDS Office, and one from the STD City Clinic. Two of the interviewers are Latinas fluent in Spanish, and one is a Filipina fluent in Tagalog. Irene added that she would request support from the HPPC for further recruitment efforts. Sacul suggested that the Epidemiology and Research Committee might be able to assist, since this committee has a list of speakers who served on its key informant panels addressing different underresearched communities at risk. She added that the people who had come to give public comment at this meeting might also have some ideas or resources for recruitment for the Delta Project. Ana Claire said that it would be helpful if Sacul could take the lead in coordinating the support of the Epidemiology and Research Committee. Isabel added that the Westside Women's HIV Prevention Project had also been recruiting for the Delta Project.

6. GOALS AND OBJECTIVES VOTE
Barbara noted that the comments (on the Goals and Objectives for the 1997 HPPC) from the Council and the committee had been incorporated into the document that was mailed with the last set of Council minutes. At this meeting, the revised document was again distributed around the table. Barbara explained that the bolded text indicates the party responsible for the completion of the objective. The last set of process objectives (the lettered items under number 4) describes activities to be completed by committees of the 1997 HPPC. Because those committees are as yet undetermined and unnamed (except for the Steering Committee), they are referred to generally as "committee(s) of the HPPC." The 1997 committee names will be added once they are known.

Liz asked whether the second process objective (regarding HPPC participation in monitoring of programs) represents a new or continuing practice. Barbara responded that, while AIDS Office staff have been monitoring programs, HPPC members have not previously shared this task.

Ana Claire asked about the standardized instrument mentioned in the second bulleted point under the first impact objective. She wondered whether the Evaluation and TA Committee would be expected to draft such an instrument, and whether this instrument would involve new types of data collection. Ellen responded that the variables (for basic demographic and basic behavioral risk information) would be taken from the behavioral risk assessment. Joshua noted that the Council had decided not to require a standardized instrument for the behavioral risk assessment, although the minimum required variables for collection were standardized. Tracey proposed that the objective could be revised to state that providers will "perform an assessment with 100% of program participants..." -- so that there is no reference to a standardized instrument. Lyn added the phrase "of individual client need" after the word "assessment," since it was not entirely clear what kind of assessment was being required.

Joshua asked if providers were really going to be expected, not only to turn in progress and quarterly reports, but to perform and document assessments with 100% of their clients. The committee confirmed that this was the intent of the recommendation. Jimmy asked whether the assessments were to be done with the clients included in the behavioral risk assessment, or with all clients. He agreed with Joshua that there are situations in which a provider cannot make thorough assessments of all clients.

Tracey explained that this impact objective had been taken and expanded from one of the objectives approved for the 1996 HPPC. It was originally written as an objective for referrals from CTRPN. The Goals and Objectives Committee wanted to create an objective for all prevention services making referrals, and to stress the importance of appropriate referral, based on thorough assessment of client need. Ana Claire suggested that the objective be expanded to list those interventions to which it does or does not apply, since assessment is not feasible for all intervention types. Barbara explained that, for CTRPN, every client needs to be personally assessed (one-on-one) for a referral -- although not every client needs to be given a referral, following the assessment. Tracey suggested looking at the standards of service provision listed in the Strategies and Interventions Chapter, to see the interventions for which the referral assessment objective would apply. She then named CTRPN, prevention case management (PCM), and one-on-one risk reduction counseling (included in the RFP, but not in the 1995 Strategies and Interventions Chapter) as the interventions for which all clients should receive a personal assessment for appropriate referral. In response to remaining questions about the required percentages of clients to be assessed, Tracey explained that the assessment should be performed for 100% of the clients receiving CTRPN, PCM, or one-on-one risk reduction counseling. She agreed to revise this objective to state that AIDS Office-funded prevention providers will:

- perform an assessment of individual client needs with 100% of program participants, for the following interventions:
  - CTRPN
  - PCM
  - one-on-one risk reduction counseling

  and will make appropriate referrals as needed and/or requested.

Ana Claire suggested that, in process objective 4. (c), "timely orientation and mentorship" be added to the list of issues to be considered in the review and adjustment of HPPC operating procedures. This change was noted for the revision of the document.

Jimmy asked whether the HPPC was expected to determine the consistent messages to be used throughout HIV services, as process objective 4. (d) suggests. Ana Claire explained that some of these goals and objectives were pulled from the HPPC goals and objectives for 1996, and were assigned new completion dates for their incorporation into the newer document. She explained that these items could still be changed, but that it had been the intent of the Council to make recommendations regarding consistency of the messages around sexual and needle behaviors (e.g., how to reconcile the different positions taken on the relative risk of unprotected fellatio). Tracey added that focus groups and other means could be used for developing consistent messages. The objective states that the consistency of messages must be ensured, but does not dictate how it should be done. Kathleen added that members can refer to the document (distributed by the Evaluation Team at this meeting, and enclosed for those absent) on the progress made on 1996 HPPC process objectives, to see that this process objective for the 1996 Linkages Committee was left blank, because it had not yet been undertaken.

Joshua suggested that another item be added to process objective 4. (c), to address the length of membership terms for the HPPC. He expressed his own feeling that three-year (instead of the current two-year) terms would allow for more overlap and continuity between Councils, and would help each Council to remember and understand the recommendations made by the previous one. This change was noted for the revision of the document.

Liz asked for an explanation of the "Strategic Evaluation Planning Consultants" mentioned in 4. (i) and (l). Ana Claire explained that there are two contracts (one with Polaris, Inc. and Harder + Co., and one with the Support Center) for the consultant support to be offered for the development of evaluation requirements and TA. While the Support Center has been working on the needs assessment and the prioritization of TA to providers, the Polaris, Inc./Harder + Co. team has been working on the development of a five-year strategic evaluation plan. Lyn agreed with Liz that the language used to describe the consultant groups should be clarified.

Ana Claire pointed out that the HPPC committee role described in 4. (m) as participation in an assessment of research progress could better be described as a role in providing guidance to researchers. She suggested the following wording:

> m) During 1997, provide guidance to those funded to implement research projects which address gaps in knowledge about behavioral transmission groups.

Roberto asked when the findings of the TA provision process would be shared with the full Council. Ana Claire explained that the TA provision will require a separate contract, the details of which are not yet determined.

Lyn stated that 4. (l) seemed to duplicate 4. (i). She suggested that a single objective be written for the guidance given for the implementation of the strategic evaluation plan, and that it leave out the description of the parties responsible for implementing the strategic evaluation plan.

Tracey noted that, for 4. (m), the intention had been to require timely presentations to the HPPC on the prevention research projects funded by the AIDS Office. Ana Claire asserted that there has been ongoing confusion over the role of research project advisory committees, and whether they are or are not part of the HPPC process. It has not been clear whether advisory committees could present to the Council on the progress of prevention research projects. Roberto asked if this item should go back to the committee for further review. Ana Claire agreed that this item should return to the committee, and added that 4. (l) would be deleted (in response to Lyn's comment).

The motion was made to accept the "Goals and Objectives for the 1997 HPPC," with all of the changes suggested at this meeting for **impact objective 1.** (second bullet) and **process objective 4.** (additions to *c.*, clarification of *i.*, deletion of *l.*, and return of *m.* to committee for revisions).

The Vote (on the motion to approve the draft document, with the revisions mentioned above)

In Favor:	13
Opposed:	0
Abstentions:	1

The motion passed.

7. BREAK

8. COUNCIL ISSUES ABOUT RFP

Kathleen Roe and Lyn Paleo facilitated this Council discussion, and Brian Dobrow agreed to speak briefly as a representative of the AIDS Office. Lyn explained that the AIDS Office would begin, after this meeting, to consider its response to each of the points raised in this discussion. Brian would only be able to offer a more general response to the Council concerns about the RFP. The time was structured to allow for 20 minutes of HPPC comments, 10 minutes of response from the AIDS Office (in this case, Brian Dobrow), and 15 minutes of wrap-up.

Lyn presented overhead projections of the Harder + Co. summaries of RFP-related concerns expressed by members (through phone and fax communications) in advance of this meeting. (The material used for the transparencies is enclosed.) She highlighted three areas of concern:

1) the 1995 Priority-Setting process (limitations of the risk groups and the overshadowing effect of prevalence data in the Matrix for scoring/ranking)
2) the RFP process, as it was approved by the Council (the point system in particular)
3) the RFP process, as it was implemented by the AIDS Office (the point system, the division of BRPs 1-7 and 8-12, and specific issues about interventions -- the VBIO set-aside, the splitting of General Ed. and Hotline, and the omission of YGC and Adult Jail Population)

The following bulleted points represent paraphrased comments from the Council RFP discussion:

Members:

- The length of time that it took the AIDS Office to respond to specific issues raised by the community was a source of great concern. These delays made it much more difficult for HPPC members to answer questions from their constituencies.
- The Council has heard significant community testimony that the RFP didn't work.
- The RFP should not have separated BRPs 1-7 from 8-12; the Council had agreed about the need for prevention services to all 12 groups.
- Venue-Based Individual Outreach seemed to receive preferential treatment (in that it was, for all intents and purposes, a set-aside, and VBIO proposals could apply for all 12 BRPs).

- Providers were rushed and held to tight deadlines, while the AIDS Office itself delayed, not even releasing the first round of awards before expecting providers to apply for the second round. It is hard to respond to the second RFP, without knowing the results of the first.
- At the Bidders Conference, an AIDS Office staffperson openly expressed a lack of awareness of and an indifference to the work of the Council -- seeming to divorce the work of the AIDS Office from that of the HPPC. This felt disrespectful, dismissive, and counter to the good faith behind this shared planning process. The Plan is not simply an HPPC document.
- The Council needs to redo the RFP/resource allocation process, if the community is convinced that funding will not be provided for prevention to non-IDU women. The Council can't wait until next year to correct these gaps in service.
- It has been frustrating to see the outcomes of the RFPs, and to experience a lack of response from the AIDS Office to various expressions of concern on part of the community. While the AIDS Office now wants to work toward better communication in the future, that doesn't help the present situation -- resulting from poor communication in the recent past.
- The separation of BRPs and the set-aside for VBIO seem pretty clearly to represent process violations of the way in which the Council and AIDS Office are supposed to work together.
- The second RFP did not, as expected, address the cut-off point (minimum score) set for the first RFP. Members thought that steps would be taken to prevent any gaps in services left by the first RFP, but major gaps seem to remain. Problems may have resulted from Council's inexperience with RFPs, and from some poor translation of the HPPC work by the DPH. The Council intended to provide a safety net, with prevention services across the board, addressing the highest risk areas (but covering all 12 BRPs). Gaps are particularly evident now for women, and especially for women of color.
- Can a pot of funding be reserved to go toward services for non-IDU female populations?
- There was no integration of Council input on the RFP process for the first round of funding. By round 2, the race was already lost. The discussions of Council concerns about the RFP process needed to happen sooner.
- There was also no apparent integration between the two funding rounds. There is a problem and an incongruity in the RFP process when certain activities cannot be proposed to serve the populations for which they are needed.
- After hearing these comments, it is hard to feel that one has done enough, as a Council member and a woman of color, to ensure that services for women of color will continue.
- Pediatric AIDS cases will also rise, if there are gaps in prevention services for women. There is reason to feel concern about the Delta study, funding, and prevention as a whole for this population. There seems to have been a disrespect for the needs of women, and for women of color in particular. The idea of a set-aside for serving women should be pursued.
- It does not seem possible to take pride or ownership in a process that does this kind of disservice to women. The matrix was impressive at first, but there are many different ways to work with numbers to approach this kind of problem. Too much weight was given to prevalence and to old data. The Council needs to look at incidence and rising rates of infection. The Matrix gives only one snapshot of the epidemic.
- The Matrix was somewhat daunting at first glance, but became acceptable because of the promise that other factors (beyond relative risk, prevalence, and population size) would be considered in the fourth phase of the resource allocation process. This seems to have been a false comfort; the fourth phase was inhibited by the insistence upon the priority of 1-7.
- It is sad to see what happened to the years of hard work. Somewhere along the way, women having unprotected vaginal receptive sex stopped figuring as a risk for HIV transmission.
- There is unusually light representation of AIDS Office staff here today, of all days.

Brian's response:

- A number of decisions were made in the AIDS Office process of production for the RFPs. Some people in the AIDS Office agreed with these decisions, while others disagreed.
- People in the AIDS Office generally agree that there was a major gap in communications between the AIDS Office and the Council, around specific issues for the RFP.
- There has been a problem of bureaucratic policies prohibiting AIDS Office staff from discussing any of the content of RFPs outside of the AIDS Office, prior to release. Had it not been for these policies, the decision to split the BRPs 1-7 and 8-12 would not have come as such a surprise the HPPC members.
- The decision to split the BRPs into two groups, with separate proposal processes (in most cases) was one of convenience for the review panel, and was intended to ensure a fair and equitable review by the expert review panel. While it may have seemed that it was done for administrative convenience, it was more so that reviewers could focus on just that component and make informed recommendations about what to include or not include in the review process.
- At this point, Brian could not address Jimmy's question about the precise amount of funding available. (Brian did say later in the meeting that the figures given in the CDC Cooperative Agreement Application fairly accurately reflect the amount of CDC funding, but do not represent other funding sources.)
- The issue of the minimum score was referred to the AIDS Office by the RA/RI Committee. The AIDS Office decision to set the minimum score at 100 did give an impression that BRPs 8-12 were being excluded. This was not the case. It was up to applicants to provide the justification for raising the minimum score so proposals covering these populations could be considered. Some applicants did just that. The AIDS Office is aware that there may still be some gaps among the BRPs or within interventions, after the entire review process has been completed. The AIDS Office has discussed options but believes that RFP 016-96 should take care of this issue. *(Additional note from Brian: We, the AIDS Office and the HPPC, will continue to look for other resources targeting all BRPs in San Francisco.)*
- The data review panel made some decisions about the proposals for BRPs 8-12. Of the 29 proposals received and given an initial review, 24 went on to the technical review panels. Others were found either to be non-responsive or below the minimum score of 100. However, one of the proposals originally rejected was then reviewed on appeal (for which an extra 10 days was needed, causing some of the delays in the AIDS Office awards process). This review was seen as necessary to give the proposers and their target population a fair chance at receiving funding.
- The grid showing the BRP proposals recommended for funding has been completed, and has been forwarded to Mitch for immediate review and finalization.
- At the next HPPC meeting, high-level AIDS Office personnel will be present to respond to the issues raised by the Council.
- Brian would personally like to see what will happen in response to gaps in the RFP process. He would not want to have the RFPs result in a break in Council participation or a break in trust between the planning process partners.

Continuing Council Discussion:

- Can these issues be discussed in this forum with Mitch, Valerie, and Gene? (Brian responded that Mitch, Valerie, and Gene will all receive a summary of the comments made at this meeting. However, he did not feel that he could guarantee Mitch's presence and

participation in the Council discussion. Roberto added that the Steering Committee was working on securing a commitment from Sandra and Mitch to attend a Council meeting.)

- It is not feasible to do "marriage counseling" (a term that Brian had used earlier to describe the need for reconciliation and communication between the HPPC and the AIDS Office) when only one partner is present and willing.
- The Council should write a letter and extend the language to address the urgent need for services for women, and not only for women of color.
- Are there other gaps in service that need to be addressed in this letter -- either specifically or as a general clause about other gaps? (Lyn responded that, at this point, nothing could be known about other gaps in services left by the RFP. Until awards were officially announced, the HPPC would not be able specifically to address other gaps in service.)
- About how much funding would the Council be able to recommend for the special allocation to programs serving female populations? (No estimate could be given at this time.)

Also in the course of this discussion, Chata officially informed the Council that he had been fired from his position at the NAAP, because of his participation on the Council and other reasons. He suggested that the AIDS Office should consider ways to facilitate participation on the Council -- by, for example, allowing agencies to count units of service for staff time spent on the Council[1].

The motion was made to approve the writing of a letter (by Co-Chairs Chata and Ana Claire) from the Council to the AIDS Office. The letter would address the gaps in service to non-IDU women, and would request that some funding be reserved for programs serving female populations.

The Vote (on the motion to write the AIDS Office a letter about the need for services to women)

In Favor:	14
Opposed:	0
Abstentions:	0

The motion was passed unanimously. To give specific input on the letter content, members were advised to speak with Chata or Ana Claire immediately after the meeting adjournment, or to call or fax their messages in to them by 3pm on Friday (September 13th).

Kathleen stressed that the dialogue boxes for meeting evaluations offer members an opportunity to register their concerns at each meeting. She asked that members use these forms to express what they are feeling to all participants in the planning process. She explained that the dialogue boxes are perfectly appropriate for serious and candid remarks, and that Kevin takes these remarks down verbatim, for the completed forms distributed to the Council. Kathleen implored members to share their thoughts and feelings for the record, rather than just sharing them privately with particular members. The Evaluation Team can only report what is offered publicly.

Jimmy thanked Kathleen and Lyn for their facilitation, and thanked Brian for taking on the burden of representing the AIDS Office at this meeting. Other members also expressed their gratitude.

9. CDC APPLICATION PRESENTATION (discussion and vote postponed for the next meeting)
Because of a lack of remaining meeting time, the discussion and vote on the CDC Application was postponed until the next meeting. Brian gave a brief presentation, and distributed the draft text of the AIDS Office application for 1997 (enclosed for those absent). (A summary of the pieces included in the CDC Cooperative Agreement Application is also enclosed for Council members).

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[1] Chata also said that this issue of units of service should be worked into the HPPC Goals and Objectives.

Brian explained that the AIDS Office is applying for a total of 7.4 million dollars in CDC prevention funds, for CBOs, DPH, and AIDS Office programs. He outlined the components of the application (see summary handout), and highlighted the **Program Specific Plans** (Scope of Work) section as the most important piece, since it explains what services will be provided to which populations by which agencies. This piece will be completed once the awards are all finalized.

10. MEETING ADJOURNMENT/EVALUATION

As the meeting closed, Chata encouraged everyone to attend the next Council meeting. He said that he has faith in the members, their work, and the overall process. He requested that all members try to revive their own faith and commitment to the HPPC and San Francisco as a whole.

Dave Hubbard of the State Office of AIDS expressed that, as someone who covers seven counties, he believes that the concerns expressed at this meeting are not unique to the San Francisco process, but are shared by other planning councils. He suggested that the differences between the Council and the AIDS Office may not be as great as they appear, and that the planning parties should be able to come to some mutually agreeable solutions. He also asked members to remain involved, and said that he had heard and felt the seriousness of the concerns of the community and Council.

11. HOMEWORK FOR CDC APPLICATION

Lyn pointed out that the CDC Application would have to be submitted on the day following the next HPPC meeting -- meaning that it would be unreasonable for Brian to try to make extensive revisions after that meeting. Ana Claire, Lyn, and Brian then suggested that members should submit all major comments for revision to Brian in the week following this meeting, so that he would have time to incorporate them. ***(Update: Since these minutes could not be mailed before 9/23 and not all Council members were present to hear the assignment, the due date for this input on the CDC Application has been extended to the evening of Tues., September 24th).***

Enclosed with These Minutes (for all members):

- LIFE Institute job announcement for HIV/Healthcare Legislative Advocate
- Letter of protest sent to Dr. Katz, regarding RFP No. 015-96 (letter provided by the guests)
- Materials projected on the overheads for the RFP discussion:
  - "Area(s) of Concern" I, II, and III
  - Article IX of the HPPC Bylaws, regarding conflict resolution
- CDC Cooperative Agreement Application summary/outline
- Updated HPPC calendar for committee and full Council meetings in September and October

Enclosed with These Minutes (for those absent):

- "Roles and Responsibilities..." draft document
- "STD Overview" flyer and registration form
- "Chron Log," "Committee Activities," and "Outcomes" updates; and 8/22 evaluation results
- LIFE Institute letter and application form for the Technical Assistance Consultant Pool
- "Delta Project Status" report
- Two pages of members's RFP concerns submitted to Harder + Co. prior to this meeting
- Draft CDC Cooperative Agreement Application text (still to be completed)
- CDC letter re: nominations for non-governmental representatives for external review teams

Next Meeting: Thursday, September 26, 3-6pm at the First Unitarian Chuch -- 1187 Franklin St.

Minutes Recorded by: Mary Irvine
Minutes Approved by: AIDS Office staffperson Brian Dobrow and Co-Chair Ana Claire Meyer

DRAFT

HIV PREVENTION PLANNING COUNCIL MEETING

September 26, 1996
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: Co-Chairs
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

Please read: Agenda, minutes of September 12, and committee minutes

Please bring: Entire package, applicable committee minutes, CDC Cooperative Agreement Application

Agenda

1.	Welcome & Introductions	Valerie Kegebein	3:00-3:05 PM
2.	Minutes from September 12	Valerie Kegebein	3:05-3:10 PM
3.	Announcements	Valerie Kegebein	3:10-3:15 PM
4.	Public Comment	Valerie Kegebein	3:15-3:35 PM
5.	Goals & Objectives - Final Vote	Barbara Adler	3:35-3:45 PM
6.	Break		3:45-3:55 PM
7.	Linkages - Vote-Referral Linkages	Chata	3:55-4:05 PM
8.	CDC Application - Vote	Co-Chairs	4:05-5:05 PM
9.	Resource Allocation/Resource Inventory - Update	Jimmy Naritomi	5:05-5:15 PM
10.	Membership - Update	Valerie Kegebein/Lyn Paleo	5:15-5:25 PM
11.	Council Issues About RFP	Mitch Katz/Gene Copello	5:25-5:55 PM
12.	Meeting Evaluation	Chata	5:55-6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please *always* check in with the receptionist on the 5th floor.

HPPC - October 10, 1996, 3:00-6:00 PM, First Unitarian Church, 1187 Franklin Street, San Francisco

SF
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#3
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DPH

HIV PREVENTION PLANNING COUNCIL
MINUTES
September 26, 1996

Members Present:
Barbara Adler
Isabel Auerbach
Christine Edwards
Ellen Goldstein
Natalie Gutierrez
Liz Highleyman
Valerie Kegebein
Ana Claire Meyer
Jimmie Naritomi
Mark Peppler
Sandy Simms
Joshua Volle

AIDS Office Staff:
Gene Copello
Delia Garcia
Marshia Herring
Mitch Katz
Mike Pendo

Guests:
Hank Wilson

Members Absent:
Ronnie Ashley
Hector Carrillo
Patrick Forte
Dale Frett
Roberto Garcia
Tony Hall
Piper Hyland
Sacul L'Adnbre
Marvin Lee
Ramon Martinez
Bethsaida Ruiz
Terry Ryan
Zwazzi Sowö
Gregory Walker
Edward Zold

Evaluation Team:
Cindy Berenstein
Ruel Caneda
Christina Goette
Kathleen Roe
Kevin Roe

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Polaris, Inc./Harder + Co.:
Mary Irvine
Lyn Paleo
Eden Tanovitz

1. WELCOME AND INTRODUCTIONS

Ana Claire and Valerie called the meeting to order shortly after 3:00pm. Those present introduced themselves around the room.

This meeting did not achieve a quorum (which would require 14 of the current 26 members to be present). With the hope that others would arrive late, the members present began by addressing all agenda items that did not require a vote. No one signed up to give public comment at this meeting.

2. MINUTES FROM SEPTEMBER 12

This item had to be postponed for the next meeting with a quorum.

3. ANNOUNCEMENTS

Valerie

- Tracey gave birth on Tuesday (9/24/96), to a 10-pound, 7-ounce baby boy by cesarian. Valerie said that both mother and baby had been doing well since the birth. Tracey's son is named Jack Leland Packer-Dawley.
- The letters of awards from RFP #015-96 were sent out via fax at about 5:15pm on Wednesday (9/25). The letters have also been mailed to those agencies awarded.
- The AIDS Office did not receive the funding for impact evaluation from the CDC, but it did receive the grant for researching behavioral indicators.
- Because of the California Co-Chairs Meeting taking place at the end of the fourth week of October, there will be only one HPPC meeting held next month (on 10/10).
- Zwazzi, Gregory, and Ramon all called to say that they could not attend this meeting.

Barbara

- A couple of job opportunities have opened at the Counseling and Testing Unit of the AIDS Health Project. Flyers with the job descriptions and contact address/phone number are enclosed for those absent. Barbara also brought an AHP pamphlet (enclosed for those absent) designed to provide information to HIV-negative gay and bisexual men.

Ellen

- CAPS has an opening for a project assistant to the technical and information exchange core, which works with community research. This and all other UCSF job postings can be found online, at the UCSF home page.
- CAPS has just received four new CDC grants:
  - for Cynthia Gomez' research project with serodiscordant gay male couples;
  - for Kung-He Choi's evaluation of an intervention with Asian and Pacific Islander gay men;
  - for Susan Kegeles' and Bob Hays' project to develop a replication package for their young gay men's community education project and to pilot it; and
  - for Maria Ekstrand's secondary data analysis on the Healthy Oakland Teens (peer education) project.

Jimmie

- At the September 12th HPPC meeting, Jimmie announced his intention to have copies of his original letter to the AIDS Office (regarding RFP# 015-96) distributed to the full Council, to give members some background on the AIDS Office response letter, which was sent to the full Council. Jimmie had not intended to release the contents of his letter to the Council as a whole, and had sent it only to DPH and AIDS Office staff, co-chairs, Steering Committee members, and Resource Allocation and Resource Inventory Committee members. However, he wished to ensure that all those who received the AIDS Office letter of response to his letter could also read the original letter of concern. Both letters, along with a cover memo from Jim Naritomi, were distributed at this meeting (handout enclosed for absent members).

Isabel

- Westside Community Mental Health Services is looking for a bilingual nurse (who speaks Spanish or an Asian language, in addition to English) for the AIDS Case Management program.

- Regarding the AIDS Office letter of response to the group of providers who wrote a letter of protest (about RFP# 015-96) to the AIDS Office -- an identical letter of response was sent to the Executive Director of Westside (Bea Stephens), although she sent a separate letter of concern, and did not sign on to the group letter.

Liz

- Was CALPEP funded to work in San Francisco? (The answer was affirmative.)

4. RESOURCE ALLOCATION/RESOURCE INVENTORY COMMITTEE UPDATE

Jimmie explained that this committee had decided to defer the concept vote on the revised resource inventory to the December HPPC meeting. He reminded members that the Resource Inventory (in its older form) constituted Chapter Two of the 1995 Plan. The Resource Allocation and Resource Inventory Committee agreed that the narrative of the chapter, as well as the matrices of services, should be re-worked to account for the paradigm shift to a focus on behavioral risk (with further definition of populations by covariates and co-factors). At the moment, the committee is focusing on the matrices, and on organizing the resource information in a way that will communicate the paradigm shift and will use the current HPPC terminology (for intervention types, for example). The resource inventory is being reconstructed in two stages:

1) an organization of the information available from 1996 contracts; and
2) a design for how the 1997 resource inventory should look.

At this point, Mike Pendo distributed his 9/25 draft (enclosed for those absent) showing the committee's design for the 1996 resource inventory matrices, which show prevention services:

- by agency funded;
- by intervention type; and
- by behavioral risk group.

The first page of this handout offers a key of the abbreviations for interventions, the funding cycles for each source of funding, and the behavioral risk populations for 1-12. Jimmie explained that the matrix for prevention services by agency would be continued to show the collaborations funded in 1996. He also noted that the pages shown in this draft are only examples of the design of each matrix; they do not provide an exhaustive list of prevention services funded. The empty column for "provider defined target population" will be completed with the descriptions in proposals of the populations to be served. This column is meant to highlight the issues that the providers regard as most relevant for serving their populations. Jimmie also explained that the inclusion in the matrix of the "provider defined target population" column will allow people examining the resource inventory to track the gradual progress of the paradigm shift in prevention. For those who have not fully adopted the HPPC-defined BRPs, co-factors, and covariates to describe their populations, the "provider defined target population" column will reveal more than the columns that follow it. As the paradigm shift is enacted, the last three columns (BRPs, covariates, and co-factors) should become more and more informative and definitive.

Regarding the names for intervention types, Jimmie pointed out that the terminology has changed somewhat with the writing of the Strategies and Interventions Chapter, and even since its completion (with the 1996 RFPs). The matrices will be updated to reflect the intervention categories in the 1995 chapter and any newer intervention categories, such as "one-on-one risk reduction counseling."

Jimmie requested that members call him (563-0553) as soon as possible, with any remaining comments on the design of the 1996 resource inventory design.

Liz asked if the matrices would constitute public information. Valerie responded that they are public information, which will be featured in the Plan, but can also be reproduced as a stand-alone document.

5. MEMBERSHIP COMMITTEE UPDATE

Valerie reported for the Membership Committee, which has not yet chosen a new chair (the committee is scheduled to select a chair at its next meeting). She offered the following information:

- The Membership Committee met on 9/17, with Lyn Paleo acting as facilitator.
- Following the meeting, Lyn called those members who had been absent, to update them and to poll them on the decisionmaking items.
- At the meeting, the group looked at the following possible tasks for Membership:
  - member retention, and incentives for participation;
  - exit interviews with members departing the Council;
  - allotment of AIDS Office staff time to call and check in with members about their attendance and any related issues;
  - revision of the by-laws, around the frequency of new member selection, term limits, and other issues;
  - production of the committee chapter, on the HIV planning process and the San Francisco planning group; and
  - collaborative production (with the Steering Committee) of a document on the roles and responsibilities of planning parties.

  (With the exception of the "roles and responsibilities" task, all of the above are scheduled for completion this year.)
- The Process Evaluation Team will assist the committee in determining why attendance has been so low recently. The evaluators are planning to conduct a survey with HPPC members.

Ellen asked if a target date had been set for the filling of empty slots on the Council. Valerie responded that, because of the other pressing business to which the AIDS Office has needed to respond of late, a target date has not yet been chosen. Lyn asked whether a decision had been made on the question of whether to bring in new members for the end of this year, or to wait until the beginning of next year. Valerie responded that no final decision had been made on this issue.

Ellen spoke as one of the members who started serving on the Council close to this time last year, and said that she would recommend bringing on new members at this point. She said that there was some benefit in beginning to serve prior to having to make any big decisions. She added that the months left at the end of the year would allow more time for mentorship before the decisionmaking that will begin in the next year of planning. Lyn asked if it was hard for Ellen, as a new member, to participate in the final decisionmaking process around the chapters, which were largely completed by the time Ellen joined the Council. Ellen responded that it had felt strange not to receive an orientation for the first eight months of her term. However, she was engaged at the subcommittee level, and eventually felt that she could participate in the Council decisionmaking on the chapters for the Plan.

Jimmie noted that this year is somewhat different from last year, partly because there are more committees operating at the same time. He suggested that new members be brought onto the Council now, because it is difficult for the Council to operate with so few participating members.

Joshua noted that beginning to serve on the Council had been confusing for everyone, regardless of whether their terms began near the end of the year or in January. He spoke in favor of bringing on the new members, and working on the timely provision of mentorship.

Natalie, who also began in the second half of last year, said that she had been uncomfortable voting on completed works (such as the Matrix). She had managed to handle her position on the Council by asking a lot of other people a lot of questions, and she said that the mentorship that she received this way was critical. She added that now she was most concerned about the fact that attendance had been hovering at just about half of the current membership, for the past three meetings.

Valerie said that she recognizes the need for mentorship and the need to walk new members through all of the issues for Council decisionmaking. She noted the time, and asked if the group was ready to get into a discussion of the Cooperative Agreement Application to the CDC, even though a formal vote would not be possible in this meeting. Barbara responded that she could present for the Goals and Objectives Committee, since this agenda item did not actually require a vote. The presentation would constitute an update on changes made in response to Council feedback given on 9/12, when the "Goals and Objectives for the 1997 HPPC" were accepted. (Note: Because the end dates of some of the objectives were changed after the Council approval, and some objectives were added for evaluation and TA-related tasks, **the revised document will be submitted for another Council vote on 10/10.** A new draft will be faxed before the meeting, to which members should come prepared for the discussion and final vote on the document.)

6. GOALS AND OBJECTIVES COMMITTEE UPDATE

Barbara said that she regretted that she did not have copies of the revised version of the "Goals and Objectives for the 1997 HPPC," which had just been completed the day before. The committee members had just been faxed the new version, but others on the Council had not seen the changes.

Barbara noted the following changes (from the previously distributed draft, which is enclosed with these minutes) appearing in the revised document:

- The second bullet under Impact Objective #1 now lists the actual interventions for which the Council agreed it was appropriate to require a risk assessment with 100% of clients.
- Process Objective #3 now reflects the fact that the Steering Committee will only be meeting once in every two-month period.
- Under Process Objective #4,
  - (c) was changed to show that the length of membership terms, incentives for participation, and new member orientation will be among the HPPC operating procedures to be considered for revision;
  - (d) was given a new date of completion (12/97), to allow more time for the dual task of making recommendations and providing training around delivery of consistent messages;
  - (f) and (g) were also given a new date of completion (8/1/97), to reflect CDC deadlines that the AIDS Office must meet;
  - (i) was changed to clarify the Strategic Evaluation Plan, and to list the standardized variables for collection;
  - (l) was deleted; and

- (m) was changed to clarify that the Council will be given research updates, and that Council members will also participate on advisory committees to AIDS Office studies (rather than serving on separate advisory committees for HPPC members only).

7. LINKAGES COMMITTEE UPDATE

This item **will require a Council vote** (with a quorum) at the next meeting, but was presented at this meeting as an update. Since Chata was absent, Mark presented for the Linkages Committee.

Mark explained that the comments and feedback offered by the Council on August 22nd were incorporated into the revised version of the "Recommendations for Referrals and Linkages" document, along with additional changes made at the September 3rd committee meeting. Most of these changes simply involved the re-wording of certain recommendations for greater clarity:

- Recommendations related to counseling and testing services now refer specfically to "anonymous and confidential" CTRPN.
- The committee also incorporated anonymous and confidential CTRPN providers into the section on "Development and Implementation of Referral Systems/Mechanisms" (#3a.).
- The recommendation about encouraging staff to form "relationships" with staff at other agencies was changed to say that providers should, "encourage personal contacts" between staff at referring agencies (#2c.).
- The two recommendations originally discussed as items for DPH implementation were combined and moved into the section for AIDS Office implementation (#2b. under *AIDS Office).*
- The requirement for use of the minimum standardized variables for documentation of referrals (#3a ii.) was clarified -- so that it does not imply that a single standardized instrument must be used across intervention types, or that the referral data can be "linked" with data from the behavioral risk assessment.

The committee also expanded the "Additional Linkages" section of the document. Eden highlighted (d), (g), (h), and (i) as the new items for *Providers*, and (b) as the new item for *AIDS Office/HPPC* in the "Additional Linkages" section.

Ellen commented appreciatively on the document, saying that it will be wonderful if the recommendations are all actually implemented. She expressed her sense that the HPPC has shown its strengths in establishing standards, and that the follow-through will be extremely important.

Mark asked if revised documents could be formatted in such a way as to highlight any changes made since the last version (using strikeouts, bolding, etc.). This would allow members to track the progress made on documents from their original to their final forms. Valerie agreed that this would be helpful, and added that the HPPC has requested that final versions be marked as **final.** Each version should also be dated.

8. CDC APPLICATION/RFP ISSUES DISCUSSION[1]

Process for Input and Decisionmaking

Valerie explained that, due to the lack of a quorum, the CDC Application could probably not be sent out on Friday, as expected. The actual due date for all applications for CDC Cooperative Agreement funding is October 4th. In order to meet this deadline, all input on the application and on the letter of concurrence or non-concurrence would have to be received and incorporated in time

[1] This section of the minutes was faxed in slightly different form to all absent Council members, on 9/27.

for a mailing on Wednesday, October 2nd. For this reason, **members were requested to submit a vote in favor of or opposed to the letter of concurrence to Valerie or Betty at the AIDS Office (via phone: 554-9023, or fax: 431-7547) by the end of the day on Tuesday, October 1st.**

Valerie said that, in addition to the CDC review, the application for Cooperative Agreement funding will be submitted to an external review panel. Any application mailed without the letter of concurrence would be deemed non-responsive, and would go to a *special* review team, which would decide how to intervene (with TA, for example) in the planning process. It is possible that this special review team would still approve the application. The letter of concurrence or non-concurrence must describe:

1) how successfully the HPPC and the AIDS Office have collaborated in the development and refinement of the San Francisco HIV Prevention Plan; and
2) whether the HPPC and AIDS Office have reviewed and agreed upon the program priorities reflected in the application to the CDC.

In other words, the letter addresses both the *process* and the *product* of the collaborative community planning effort.

Kathleen offered an option for gaining input from other Council members, both for the letter and on the broader issues of concurrence. She said that the process evaluators could conduct a brief survey on Friday, to learn how the other members were feeling and why they had not attended this crucial meeting. As much information as possible (from the analysis of the survey results) can then be released to the full Council next week. Kathleen noted that some members may have had to be absent for personal reasons (e.g., starting school, going through job-related changes, or feeling ill). She wanted the Council to recognize that some absences might be unrelated to the issues of concurrence.

Ana Claire offered some options for gaining a vote on the letter for the application:

- Call an emergency meeting for the vote. (Ana Claire pointed out that this would be difficult, however, for those members who were present at this meeting, and who should not be penalized for their consistent attendance.)
- Have a drop-in voting process on Friday at the AIDS Office, for those unable to vote at this meeting.
- Go ahead with the discussion at this meeting, and send in a letter of concurrence with the application (with the consent of those present), but explain to the CDC that the letter did not receive a formal vote of approval, due to the lack of quorum.

Valerie explained that, if the Council chose to take the third option above, the application could still be mailed to the CDC on Friday. The other options would require more time, and a mailing of the application in the following week. She informed the group that Brian would be on vacation after Friday, and would not be at all available to make changes to the application. There would be limited time and personnel to take on the responsibility of making any revisions needed after Friday. Brian spoke up to request that members submit any final suggestions they have on the scope of work and/or progress report sections of the application to him after the meeting or on Friday. They would have to be faxed by the end of the day, so that he could incorporate them before leaving for vacation.

Valerie suggested that the people present begin the discussion of the application and then make the decision about how to approach the letter of concurrence or non-concurrence. Jimmy explained

that the recommendations he would make on the application would depend partly on whether the application was being mailed on Friday or in the following week. He added that there had not yet been time for members to look at the revised draft. Valerie stressed that the application could be mailed no later than October 2nd. Ana Claire suggested that *anyone* unprepared to give a definite vote at this meeting (including members present who would need more time to review the newer draft of the application) could call or fax in a vote to the AIDS Office by the end of Tuesday. Jimmy agreed, saying that the votes at this meeting should be added to the votes received after the meeting, for the final count.

Content of Application
Joshua asked whether this version of the application contained any substantive changes from the draft distributed at the previous HPPC meeting. Valerie responded that the major differences begin on page 7, where the agencies awarded for RFP #015-96 are named. Starting on page 10, the application lists the agencies proposing to reach a given BRP, and the interventions proposed by those agencies for that BRP. Valerie explained that most proposals requested more funding than could be awarded, so it is unlikely that the agencies will be able to serve all populations they proposed to serve with all the interventions they proposed to do. In order to avoid a duplication of service, only a limited number of agencies will be contracted to perform VBIO and PCM (both of which were proposed by a majority of the applicants)[2]. During contract negotiations, other cuts will probably have to be made in the number of BRPs served and the number of interventions performed, in order to set realistic objectives for the amounts of funding awarded. Also because of the differences between funding requested and funding awarded, the actual number of clients to be served by each agency cannot yet be determined. The numbers given in proposals were omitted for the Cooperative Agreement Application to the CDC. Other changes made for this most recent draft of the application were largely editorial.

Meaning of a Letter of Concurrence
Ellen asked whether the HPPC letter of concurrence amounts to an expression of agreement with the process for proposal selection. Valerie responded that the letter should express whether or not the RFPs reflected the priorities established in the Plan and during the planning process. A letter of concurrence indicates **acceptance of the priorities, as well as the activities and populations funded**. It does not have to do with the individual organizations selected for awards, however.

Coverage of Populations with Services
Referring to pages 10-14, Valerie explained that the arrays shown for interventions by BRP suggest that the objective of reaching each behavioral risk population with a range of intervention types has been met. However, the final arrays cannot be known until contract negotiations are completed (to determine what interventions can and should be performed by which agencies, with the actual funding amounts awarded).

Barbara asked whether transgendered clients were being included in each of the BRPs, and whether it could be assumed that an agency serving a given BRP would be serving transgendered persons within that BRP as well. Valerie responded that Living Well, TARC, NTFAP, and Proyecto are the main agencies expected to serve transgendered groups specifically. She noted that these agencies had highlighted their ability to serve transgendered persons, and had discussed in the proposal narrative how they would target transgendered groups with prevention. Other proposals listed the BRPs to be served, without explicitly mentioning transgendered groups. Isabel expressed

[2] Please see the note about VBIO and PCM and non-duplication of services, on page 9 of the application.

concern that the need to highlight the intention to serve transgendered clients was never before discussed in relation to the proposal process. She explained that she had assumed that serving a BRP would mean serving all those who fit the HPPC description of the BRP, including the appropriate pre-op and post-op groups. Ellen spoke as a proposal reviewer, saying that commonly an agency will claim (in the beginning of a proposal) that it will address a certain population, and then not follow through with a discussion of the considerations or the interventions appropriate for that population. The inclusion of a more specific discussion distinguishes an agency that is knowledgeable about a population and prepared to meet its particular prevention needs.

Currently Unavailable Information (related to the activity-based RFP)
Jimmy asked whether VBIO (VBIO as a collaboratively performed intervention, not "outreach" as a method of client recruitment for programs) was included in the CDC funding. Valerie responded affirmatively, but said that the majority of VBIO funding will be determined by the selection process for RFP 016-96, the outcome of which cannot be reflected in the Cooperative Agreement Application to the CDC. Ellen pointed out that the application includes a note (page 7) that the funding for proposals submitted in response to RFP 016-96 has not yet been awarded, and so cannot be discussed here. Valerie added that the awards for the second RFP cannot be made by October 2nd (the due date for proposals is September 30th), and that the application will include a contractual line item with a dollar amount (but nothing else) for each of the activities to be funded in the second round. She acknowledged that the application must be submitted with some known factors and some unknown factors. Jimmy asked whether these undetermined issues would cause the application to be viewed as non-responsive. Valerie replied that the list of activities to be funded and their funding amounts would suffice to show that the application is responsive. She added that, prior to the external review process, the AIDS Office can still send in any other pieces that will make the application more complete. The CDC reviewers would not see such pieces that are submitted after the due date, but the external review panel would. On past applications, the AIDS Office has taken this opportunity to send in additional information for the external review.

Valerie clarified that the pie charts show where the funding for RFP #015-96 is going (with no separation yet of the funding by source), but that these charts do not account for any of the funding in RFP #016-96. The charts will become obsolete (and should be discarded), once the second round of funding has been allocated. Barbara pointed out that the CTRPN amount (shown on the separate budget sheet) could also be expected to change with the awards for RFP #016-96, since CTPRN is one of the activities included in that RFP. Valerie confirmed that this amount would change, and that part of the amount shown on the line for "Contracts with CBOs" would be moved up to the "CTRPN" line. She explained that the AIDS Office has to report on the seven CDC categories shown on the budget sheet, and that a number of the AIDS Office categories for funding were lumped together under Heath Education/Risk Reduction for this application. Ana Claire asked for clarification on whether the yellow sheet shows the CDC budget only (not combining all funding sources). Valerie verified that the sheet only includes CDC funds.

Jimmy noted that a great deal of information could not be supplied until the AIDS Office had negotiated its prevention contracts, and he asked at what time this would be done. Valerie responded that contracts would have to be in place before January 1st, when the new services begin. Jimmy asked if it would reflect badly on the AIDS Office and the HPPC that this information could not be included in the application. Valerie answered that the CDC has never asked for the actual contracts made with agencies, or for the numbers of clients to be served. Instead, the CDC expects to see:

1) which organizations were selected for awards;

2) what was the method of selection;
3) what dollar amount was awarded;
4) the nature of services to be provided; and
5) the term of the contract.

Ellen added that it does not reflect badly on the community planning effort that some information cannot be supplied at this time, because the San Francisco RFP process cannot be expected to change to fit the CDC timeline. The CDC works with 65 planning jurisdictions, all of which have different timelines for resource allocation. Valerie said that the AIDS Office would later be able to tell the CDC which populations were actually served and in what numbers (using the standardized variables to be collected by providers).

Proposal for Letter with Caveats / Articulation of Council Concerns (and AO Response)

Returning to the issue of the letter of concurrence, Ellen said that the piece about program priorities has not been such a source of disagreement as has the collaborative process. Since July, the frustration of members has largely focused on the failures of communication between planning parties, and issues around what came out of the priority-setting work. Ellen proposed the following attachment to the application to the CDC:

⇒ a letter of HPPC concurrence, with a caveat that the HPPC is requesting TA and some mediation on the collaborative process, from a CDC program officer or from the local Process Evaluation Team.

Joshua spoke as a former member of the 1995 Priority-Setting Committee, and said that he supports the Matrix. He noted that the recent letter sent by Gene Copello to the HPPC membership suggests that the priority-setting process accurately reflects the epidemic in San Francisco. However, Joshua said that he found it unsettling that only two agencies had been funded to serve the broad population of non-IDU women. From a public health perspective, it makes sense to ensure that the rate of infection among women in San Francisco stays low. Joshua said that he agrees with the need to consider the future of the epidemic, and to meet the *prevention* needs of women (although prevalence may be low).

(At this point in the discussion, Valerie took a moment to welcome Mitch Katz and Gene Copello, who had just arrived. She invited them to participate in this Council discussion.)

Jimmy said that, because there was not an earlier process for prevention RFPs and awards, it was not possible at this time to determine the degree to which the various BRPs, covariates, co-factors, and interventions would be covered. Without this kind of detail, he didn't feel that the Council could evaluate the RFP process or identify gaps in services. The Council will continue to work on these larger tasks in the coming year, but cannot perform this kind of analysis in time for the application. Jimmy asked whether other Council members were basically comfortable with the coverage (in proposals selected) of the BRPs.

Isabel stated that she was not comfortable with the coverage of BRPs, and could not concur with the program priorities reflected in the application. She said that she did not feel that she had agreed to these priorities or had expected the planning process to lead to this. While she said that she understands that women represent only 3% of AIDS cases in San Francisco, she also understands that numbers can be manipulated in different ways, for different results. She explained that she has witnessed that the women served at Westside Women's HIV Prevention Project are not served elsewhere, and that the data on their specific areas of risk (within the larger category or FSMs) is not yet available.

Barbara said that the application seems to match the HPPC guidelines for the BRPs (1-12) and interventions, but that it is impossible to know the content of proposals. She stressed that a great deal must be assumed by the Council (in order to write a letter of concurrence), and must be left to trust in the AIDS Office and the review panels.

Joshua expressed his own concern and uncertainty about whether the Iris Center and Haight Ashbury Free Medical Clinic would be able to serve such a large group of women, and whether the second awards process would succeed in filling service gaps for this population. He asked Isabel if she could, for the Council, expand on her concerns.

Isabel said that she still has concerns (that have already been expressed in the Council) about the Matrix as an untempered tool, the first trial of which raised a number of troubling issues. She reiterated the concern that prevalence was given such a priority over incidence, in the assignment of risk scores to populations. She said that she had been looking at surveys with sex workers. While she was unsure whether there would or wouldn't be an epidemic among women in San Francisco, she was concerned about what might happen if San Francisco relaxed its prevention efforts with women at this point.

Mitch said that no RFP or priority-setting process for resource allocation is perfect, and that the intention of the local community planning process has been to make San Francisco's prevention model better. The HPPC made a bold move, by basing the resource allocation process almost entirely on risk behaviors. The Matrix was the work of the HPPC, and there should be some acknowledgement now of the desire to move forward and see where this newer methodology leads prevention. Mitch expressed his sense that the RFP process followed through on the priorities of the HPPC, and that further discussion of the specific agencies chosen for awards would not be helpful at this stage. He described the review process as extensive and objective, with a group of community people making the best decisions they could. He added that he thinks that the BRPs are covered, but that only the future can tell whether they have been covered in the right proportions. The HPPC has built in a strong evaluation component to the requirements of the Plan, so that it will be possible to see what has worked. In the next year, the priorities may be revised and shifted as needed, along with the Matrix. Mitch emphasized that, for now, it would be important to take the step of allocating resources, and to take the community planning work beyond the level of discussion and into practice.

Natalie reminded the group that the Council had, at the last meeting, approved the writing of a letter by the community co-chairs (for the Council) to the AIDS Office, with a request for more funding of prevention interventions to non-IDU female populations. She said that, with so few people present at this meeting, she was uncomfortable with the task of deciding whether to write a letter of concurrence with the application to the CDC. She pointed out that some of those absent were most likely making a choice not to attend because they felt they could not give their concurrence.

Jimmy suggested that, if most of the people present would agree that the basic elements of the Plan are reflected (along with the goals and objectives of the planning process) in the application, that they go ahead with the letter of concurrence, adding the caveat that it is an objective of the HPPC to evaluate the RFP process, and that this evaluation cannot be completed at this time.

Valerie called a **straw vote,** to see whether there was sufficient concurrence to pursue the idea of a letter of **concurrence with caveats.** Of the 11 members present at this point, **8 voted in favor** of taking this course of action. None were opposed, but three abstained.

Joshua summarized some of the issues that he felt should be included among the caveats:

- the weighting of prevalence in the Matrix, and its impact on the final risk scores;
- the confusion caused by the Bidder's Conference -- which offered very little TA;
- the breaking out of two to three different proposal processes (some agencies had to put in three separate proposals); and
- the lack of timely information, for providers applying for the first RFP, about what would go into the second RFP.

Joshua expressed his own sense that the process would work out well enough in the end.

Liz added support to Natalie's assessment that some members were "voting with their feet," by not appearing at this meeting. She voiced her concern that the issues of the Council might not be addressed, if the Council were to submit a letter of concurrence.

Mark wondered if the Council would have any recourse, should it recognize later that significant service gaps remain, and that the Council recommendations were not well implemented.

Mitch suggested that members ask themselves what percentage of the Council's wishes were implemented. He described his own thoughts about how processes can be disappointing, and how communication failures occur even in long-term relationships with loved ones. He explained that none of the problems that occurred were the result of an intent of the AIDS Office to reject or oppose the Council's recommendations. Then he noted some major accomplishments of the San Francisco community planning process:

- the commitment of City and State resources (as well as CDC resources) to the HPPC priorities, even though this funding did not have to be included in the same allocation process; and
- the success of the HPPC in convincing Mitch Katz and others that the entire RFP process should be rebuilt from scratch, in order to bring about the paradigm shift.

Mitch said that the decision to split groups 1-7 from groups 8-12 was probably wrong, but that it had been made in good faith. He stated that the letter of concurrence relates to this issue of whether a good faith effort was made to meet the priorities of the HPPC. He made the point that the RFP process can be changed next year. Finally, he told those present that they should not think that a letter of non-concurrence would not affect overall funding levels for prevention, because it most likely would impact the amounts of the current and future awards. The CDC uses its funding partly as a reward for successful prevention planning.

(At this point, members noted that it was already 6:00pm. Barbara, Liz, and Natalie had to leave shortly after 6:00pm. Others agreed to stay to continue the discussion.)

Ana Claire said that she felt torn, and had had to abstain from the straw poll. She felt that the HPPC priorities were met in some respects, and not in others. She thought that some very significant mistakes were made, and could not be ignored. She added that the Council should assume that it would take at least two years before large funding changes could be made.

Barbara said that she was aware that HPPC members had reviewed the second RFP, and that she trusts those people to make good, informed decisions on issues related to serving women. She explained that HPPC members like herself had trusted the planning process, until the release of the RFPs, when many members stopped trusting themselves or the process. She wondered what members would have thought if there had been only a single RFP process, which had produced just two awards for agencies targeting female populations. Then Barbara expressed her faith in the proposal reviewers, and said that the issues that need to be improved could be addressed next year -- if people stay with the Council, and continue to work for change from within the process, rather than removing themselves from it. She added that any evaluation which shows a provider to be out of compliance with the contract should be considered seriously.

Ellen returned to the letter of concurrence, which she said should be written, but with caveats that are very strongly worded. She explained that the communication issues had had a significant impact on the outcomes of the process. She noted the following caveats:

- The Council requests TA/mediation, for a process that has been fraught with difficulty.
- The Council can only concur with what it sees to date, which only accounts for the first round of awards. It is not yet possible to say whether there is comprehensive coverage of the behavioral risk populations. The Council can try to trust, but can only really concur with what appears in this application at this time.

Jimmy said that this was the first time he had heard anyone from the AIDS Office management say that the splitting of the BRPs may have been a mistake. He stressed that the intention of the HPPC had been to capture the highest risk elements of every BRP (1-12). The RA/RI committee decision in favor of a simultaneous treatment of all BRPs came at the end of a long and arduous process, and was then approved by the HPPC. The split may have been made by the AIDS Office to facilitate the review process, but risk scores alone could have been used to separate the proposals received, for the purposes of expedient review. Jimmy agreed that the process had not been perfect, and had left the Council feeling unable to do anything constructive for the past few months, but he asked everyone to think carefully and make a clear decision about the letter of concurrence.

Sandy shared her experiences with the State planning group, which has also gone through tremendous "growing pains." She said that one county had discussed the possibility of a letter of non-concurrence with the State process, and that this possibility had brought up major red flags. She said that she sympathized with the effort to act in good will and to work collaboratively; and she expressed her sense that a letter of non-concurrence would lead to greater government control and greater interference with the functioning of the community planning group. Finally, she described San Francisco as a leader for California, which is seen as the leadership of the U.S. on HIV prevention planning. She felt that a letter of non-concurrence, or even a list of caveats, should be considered in light of that weighty responsibility and position.

Joshua spoke to explain that the Council members were in no way taking lightly the possibility of a letter of non-concurrence. He stated that the members do understand the implications and repercussions of a letter of non-concurrence, and that they would be entering into a battle by choosing this course of action. This is why the group had moved toward a consideration of a letter of concurrence with caveats. He added that the process may actually need federal intervention at this point -- and that, hopefully, this could happen quickly, if it should have to happen at all; but the process might require more extensive federal involvement.

In response to a concern expressed by Jimmy, Ellen noted that the Plan already includes many checks and balances for the communication needed between planning parties. Lyn reinforced this point, citing the goals and objectives for the HPPC. She then summarized the concerns and caveats mentioned up to this point (see the summary section below).

The Vote (on the writing of a letter of concurrence, with the caveats shown below)

In Favor:	**6**
Opposed:	**1**
Abstentions:	**1**

(Only 8 members remained in the room at this point. Passage of the motion would require a majority of Council members to approve it, through additional votes by fax/phone.)

Members present agreed to gain input from absent members by sending out a rushed fax of the discussion and requesting that all those who had not yet voted call or fax in their votes to the AIDS Office by Tuesday. Although there is no provision in the by-laws for a fax or phone vote, a special exception was made in order to be able to send in a complete application to the CDC (which requires a letter of HPPC concurrence or non-concurrence). The notes on the discussion of the letter of concurrence were faxed to absent members on Friday 9/27, to assist them in the process of voting. In addition, all those who were absent were messengered the revised draft CDC Application (with the information from the programs awarded in the first RFP process -- RFP #015-96), the page explaining the requirements for letters of concurrence or non-concurrence, the "1997 CDC Cooperative Agreement Application Budget by Program" page, and the pie charts showing targeted funding amounts by specific population.

Summary for the Voting Process (Lyn's notes with some revisions/additions from Mary):
If the majority of Council members adopt the motion, the letter of concurrence (with concerns/caveats) will include the following points and will be signed by the three Co-Chairs. If the motion fails, no letter will be included in the application.

1) Extent to which grantee and Council have successfully collaborated in developing the Prevention Plan: The plan was developed through collaboration with Council members and AIDS Office staff participating on committees. Each committee developed recommendations in a particular area and the Council voted on these recommendations. The Council then adopted the entire revised plan in December 1995. An update of the plan is in progress, and new areas of recommendations have been developed and adopted during 1996.

2) Extent to which the Council reviewed and agreed upon the priorities contained in the Application: The priorities contained in the application generally match the priorities agreed upon by the Council; however, there are significant concerns on the part of the Council regarding implementation of these priorities through the RFP process (see below).

3) The process used to obtain concurrence from the Council on the CDC application: On September 12 and September 26, time during regular Council meetings was devoted to two items: (1) Council concerns about the RFP process and (2) the CDC application. At the September 26th meeting, a quorum was lacking, so a preliminary vote was taken among members who were present. Information was sent to absent members and a vote was

requested from them via fax or telephone. At the Council meeting on September 26, Council members made a motion to write a letter of concurrence with concerns, and listed the following concerns:

A) The priority-setting model developed in the second year of planning needs to be reassessed and revised.

B) The Council has serious problems with the implementation of the priority-setting process through the Request for Proposals process of 1996. Specifically:

i) The AIDS Office required that a separate proposal be written for Behavior Risk Populations (BRP) 1 through 7 and 8 through 12 -- a requirement that violated the intent of the Council's recommendations and put unfair burden on providers serving non-IDU women. Further, the funds were split between two RFPs which were issued at different times, placing an unfair burden on providers who were unsure which RFP to respond to.

ii) Venue-based individual outreach was established as a set-aside activity in the AIDS Office's RFP, against the Council's recommendation.

iii) Training for provider applicants on how to calculate a minimum score was inadequate.

iv) There may be gaps in services for lower-priority groups as a result of these implementation activities.

C) Communication between the AIDS Office and the Council has been fraught with frustration and difficulty, and technical support or mediation is requested.

D) **The Council can concur only with the decisions reflected in this application. Since the second round of awards has not been completed, the Council can only offer its concurrence with what has happened up to this point in the RFP process.**

Enclosed with These Minutes (for all members):

- Previous draft of "Goals and Objectives for the 1997 HPPC," from the 9/12 HPPC meeting
- Updated calendar of HPPC-related meetings currently scheduled for October and November

Enclosed with These Minutes (for those absent):

- Two notices of job openings in the Counseling and Testing Unit of the AIDS Health Project
- An AIDS Health Project informational pamphlet for HIV-negative gay and bisexual men
- 9/24 Memo to HPPC members, and the 8/7 and 8/28 letters (to and from the AIDS Office, respectively) regarding Jim Naritomi's concerns about RFP# 015-96
- 9/25 draft matrices for the 1996 resource inventory design
- Revised draft of "Recommendations for Referrals and Linkages," ready for a final vote
- 9/12/96 "Evaluation Results" and "Participant Dialogue" boxes

Next meeting: Thursday, October 10th, from 3-6pm at the Unitarian Church (1187 Franklin)

Minutes Recorded by: Mary Irvine
Minutes Approved by: Co-chair Valerie Kegebein (Community co-chair approval was not ready by 10/7.)

Please Note Time Change

HIV PREVENTION PLANNING COUNCIL MEETING

October 10, 1996
4:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

Please read: Agenda, minutes of September 12 & 26 and revised Goals & Objectives, Recommendations for Referrals, HPPC By-Laws, and committee minutes

***Please bring*:** **ALL OF THE ABOVE**

Agenda

1.	Welcome & Introductions	Chata	4:00 - 4:05 PM
2.	Minutes from September 12 & 26	Chata	4:05 - 4:10 PM
3.	Announcements: - Letter of Concurrence - RFP Update - Timeline - Steering Committee Report	Valerie Kegebein/Ana Claire Meyer/Lyn Paleo	4:10 - 4:20 PM
4.	Public Comment	Chata	4:20 - 4:40 PM
5.	Goals & Objectives: - Final Vote	Committee Members	4:40 - 4:50 PM
6.	Break		4:50 - 4:55 PM
7.	Linkages - Vote - Recommendations for Referral Linkages - Definition of Successful Referrals	Chata/Committee	4:55 - 5:10 PM
8.	Resource Inventory - Vote - Resource Inventory - Old Paradigm - Resource Inventory - New Paradigm	Jimmy Naritomi	5:10 - 5:35 PM
9.	Membership - Update and By-Law Review	Committee/Chair	5:35 - 5:55 PM
10.	Meeting Evaluation	Chata	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

NOTE: No HPPC meeting on October 24, 1996.

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HIV PREVENTION PLANNING COUNCIL
MINUTES
October 10, 1996

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Members Present:
Ronnie Ashley
Isabel Auerbach
Christine Edwards
Roberto Garcia
Ellen Goldstein[1]
Liz Highleyman
Valerie Kegebein
Sacul L'Adnbre
Ana Claire Meyer
Jimmie Naritomi
Bethsaida Ruiz
Terry Ryan
Joshua Volle

AIDS Office Staff:
Mike Pendo

Polaris, Inc./Harder + Co.:
Mary Irvine
Lyn Paleo
Eden Tanovitz

Members Absent:
Barbara Adler
Hector Carrillo
Patrick Forte
Natalie Gutierrez
Piper Hyland
Ramon Martinez
Mark Peppler
Sandy Simms
Zwazzi Sowo
Gregory Walker
Edward Zold

Process Evaluation Team:
Cindy Berenstein
Ruel Caneda
Christina Goette
Kathleen Roe
Kevin Roe

Guests:
Hank Wilson, Epi./Re. Committee, ACT UP Golden Gate

1. WELCOME AND INTRODUCTIONS

When the co-chairs convened the meeting slightly after 4:00pm, only 12 members were present. This number was insufficient for the current quorum of 13. As a result, all decisionmaking had to be postponed to the next Council meeting with a quorum.

Note from the Co-Chairs

Because 1996 is coming to a close, and there is only one meeting in November and one in December (which should be devoted to the approval of the 1996 Plan and a celebration of the work completed by this Council), the items requiring a vote must be addressed on November 14. **This means that the Council must succeed in reaching a quorum at the November meeting** (and at the December meeting, if the Plan is to be approved). Members are requested to make the greatest possible effort to attend, in order to ensure that the business of this year is not left undone. **Those who know that they absolutely cannot attend the meeting on November 14 (or on December 12) should not fail to call Brian Dobrow in advance (554-9499),** so that he will know the number of members planning to attend that meeting. Those who plan to attend but, because of a last-minute emergency, cannot make it to the meeting should make every effort to contact a co-chair or a consultant directly, before the meeting begins. Again, if a quorum cannot be achieved at this meeting, voting items **cannot** simply be postponed to the next meeting. To prevent the necessity of making other, more time-consuming and complicated provisions to complete the required 1996 votes, members are **strongly advised to attend this meeting, despite any inconveniences.**

[1] Ellen had to leave during the announcements portion of the meeting.

2. MINUTES FOR SEPTEMBER 12 AND 26
Approval of the minutes had to be postponed for a quorum.

3. ANNOUNCEMENTS

- *Membership/Attendance:* Valerie announced that the Process Evaluation Team had found, in its phone surveys, that some Council members were planning to resign, although they had not yet written formal letters of resignation. Those who informed the evaluators of their plans to resign include:
  - Dale Frett, who has had an especially heavy workload lately;
  - Tony Hall, who indicated disillusionment with the planning process after the Retreat, and who then moved to England;
  - Joshua Tager, who has also had an especially heavy workload; and
  - Marvin Lee, who is changing jobs and will be replaced by someone else working with the San Francisco Unified School District. (Marvin also specifically called ahead, to say that he couldn't attend this meeting.)

  Valerie informed those present that Barbara, Hector, Patrick, Natalie, Mark, Sandy, and Ed had all called to say that they could not come to this meeting, but that they would continue to serve on the Council and attend future meetings.

- *Letter of Concurrence:* Ana Claire announced that the HPPC letter of concurrence with the AIDS Office application to the CDC had been sent out on the previous Thursday evening (October 3rd). The vote on the motion to approve a letter of concurrence, with a list of HPPC concerns, was finalized with 16 members in favor, 2 members against, and 3 members abstaining. The letter was then mailed with an attached statement of HPPC concerns (letter and statement of concern are enclosed for those absent). The AIDS Office has drafted a letter of response to the statement of concern, and this letter will also be mailed to both the CDC and the HPPC.

- *RFP Update:* Valerie informed the group that 33 proposals had come in response to the second RFP (#016-96), including:
  - 11 for General Education;
  - 7 for Venue-Based Individual Outreach;
  - 13 for Counseling and Testing;
  - 1 for Condom Distribution; and
  - 1 for Provider Training.

  At least two of the proposals were disqualified in the first stage of review (**Note from Valerie:** These were disqualified because of a lack of basic requirements, such as the required budget forms, and receipt by the due time). She said that the in-depth review process would take place on the 15th, 16th, and 17th of October, and that the AIDS Office would attempt to make awards between two and three weeks after the review dates. She explained that she hoped for, but could not promise, the completion of awards on this timeline. Valerie added that a couple of HPPC members sit on the review panels.

- *Timeline for the Writing of the Plan:* Lyn stated that the group of people assigned to write/rewrite sections of the Plan has met to discuss the timeline, outline, and formatting; and is now in the process of writing the individual sections, which have begun to be submitted for review by committees. Lyn explained that many pieces of the Plan will look

familiar, since they were first produced for the 1994 and 1995 versions. Lyn then announced the dates set for chapter review by the different committees:

- ° Epidemiology and Research -- October 29th, November 19th;
- ° Evaluation and TA -- October 1st, 18th, 30th, and November 7th;
- ° Membership -- November 6th;
- ° Linkages -- November 5th;
- ° Goals and Objectives -- November 4th; and
- ° Resource Allocation/Resource Inventory -- November 7th *(a new date, set on 10/15).*

Lyn added that all completed drafts of the chapters will be submitted to Harder + Co. on the 12th of November. The full Plan will then be reviewed by the Council in early December, for discussion and adoption at the HPPC meeting on December 12. She asked that members reserve some time in the week before that meeting, to review the Plan carefully, in preparation for its final approval.

- *Steering Committee Report:* Valerie gave a brief report on the Steering Committee, which met on Friday, October 4th. She explained that the meeting had included the following activities:
  - ° revision and approval of the agenda for this (10/10) Council meeting;
  - ° development of a streamlined version of Robert's Rules, on which the Council will hear a presentation in November;
  - ° discussion of what additional follow-up is needed, if any, regarding members' concerns about the RFP and the AIDS Office response (the Evaluation Team would collect members' input at the break, as to whether Mitch and Gene should be invited to the November Council meeting[2]);
  - ° discussion of membership issues (the co-chairs will send committee chairs a memo regarding the recent resignations, for the revision of committee membership lists, and the Membership Committee will handle bylaw revisions around membership); and
  - ° continuation of the work on the Roles and Responsibilities document (which will be ongoing in its development).

- *Evaluation Team Report:* Kathleen Roe summarized that the phone and fax communications conducted with Council members to document reasons for the recent drop in attendance revealed no clear trend behind the absences. Of the 15 members who were absent from the last HPPC meeting, 13 responded to the query from the Evaluation Team:
  - ° 4 were on planned vacation time;
  - ° 2 were overwhelmed by work, but intended to continue on the Council;
  - ° 2 were experiencing personal crises that demanded their immediate attention;
  - ° 1 was disillusioned/upset with the process (since the Retreat), and planned to resign;
  - ° 1 was caught up in a training;
  - ° 1 was undergoing a job change;
  - ° 1 was ill; and
  - ° 1 couldn't fulfill the time commitments required for participation, and planned to resign.

[2] A majority of those present said "yes" to the idea of having them back, and also said that they felt their questions had been answered. (**Note from Valerie:** It was decided that Mitch and Gene will be invited to a future meeting before this Council disbands, provided that there is a specific topic they can address.)

Based on the information revealed through this contact with absent members, the process evaluators reached the following conclusions:

1) The Membership Committee and Council as a whole should acknowledge that the reasons behind absences are various, and do not indicate a general shift in attitude.
2) The Council members tend to work hard at their jobs, as well as on the Council.
3) The Council is too small to absorb the losses caused by these pressures on members.
4) There has been a theme of people dealing with a small staff at work, and not being able to get away for the meetings.
5) It is unfortunate that there was not sufficient outreach to the person who expressed disillusionment with the Council -- a thriving Membership Committee would have been better able to address such needs and concerns.
6) The San Francisco HPPC has not always been as sensitive as one might expect to people's illnesses and struggles with HIV, and may have missed a very important issue for participation, which requires further examination.

Isabel asked what had happened with the original rule that any member missing two meetings would be taken off the Council. **(Note from Valerie:** In the future, the Membership Committee will be charged with issues of membership retention; but, currently, it has been the responsibility of the co-chairs. At this meeting, it was incorrectly noted that the Membership Committee was responsible for membership retention, but this responsibility has not yet begun for that committee.)

Joshua said that the Evaluation Team report demonstrated that the Council members had not been paying enough attention to caring for themselves and each other. He suggested that a representative from each committee, or a separate committee entirely, should take on the task of looking after the well-being and participation needs of Council and committee members. Joshua expressed his feeling that Council members ought to know when issues like illness and disillusionment are arising for other members.

Roberto said that he had been bothered by the assumptions (at the last meeting) that absent members were making a statement through their absence. As a member who could not attend that meeting, he felt unfairly judged. He suggested that it would be important to keep track of reasons for absences, and to inform the Council of the explanations that members offer when they call ahead with notification of their inability to attend.

Liz pointed out that the time commitment required of Council members had turned out to be greater than the time commitment to which they had agreed. She suggested that prospective members should be made aware of the actual amount of time spent on Council business, before they agree to serve. If people are encouraged to join on the basis of an underestimate of the time commitment, then they are likely to miss meetings or to drop out of the Council entirely.

Jimmie expressed his sense that it is the reponsibility of the committee chair to call members of that committee and check in about their participation and other concerns. He explained that, in his experience as a chair who calls his committee members regularly, he has found that those who are most overwhelmed tend not to respond as readily to such calls. He also mentioned that the Council used to keep an attendance chart, which would be easy to fill in from the minutes. He thought that a periodic review of the attendance

chart would assist with outreach efforts to people whose attendance has dropped. Currently, it is somewhat rare for Council members consciously to make efforts to reach out to each other, because they don't always realize the extent to which others have been missing meetings. An attendance record would raise everyone's awareness of these issues, and of the people who may need more support to continue. Jimmie seconded Liz' testimony about the unrealistic expectations for the amount of time that members would have to commit to the planning process; he, too, was unprepared for the demands of membership, and saw that some of his fellow committee members were discouraged by the time requirements.

- *Personal Statement from Valerie Kegebein:* Valerie stated that the co-chairs meet on a weekly basis, and that they realize that this has been a year "frought with difficulty," as Ellen stated at the last meeting. The concerns of the Council around AIDS Office implementation of HPPC recommendations have now been discussed at HPPC meetings, at the Retreat, and at the Steering Committee.

  Valerie said that everything that the AIDS Office has done around implementation of the HPPC priorities has been done in good faith. While she wanted personally to acknowledge that the AIDS Office had made some errors in judgement, she also wanted to clarify that those decisions had not been made in order to undermine the work of the HPPC. She said that, in writing numerous response letters to complaints and protests over the AIDS Office implementation of HPPC directives, she has had to think a great deal about the pains of this planning process and the reasons for them. She explained that she had not been able to anticipate the impact that the changes and decisions made by the AIDS Office would have on the Council and community, and that the implementation stage had been a learning experience for everyone involved -- people at the DPH, as well as people on the Council. She stressed that the AIDS Office staff are fully committed to community planning and to maintaining a collaborative relationship with the HPPC. At this point, she said, she would like the Council to move forward, to begin to regain trust, to define expectations, and to delineate Roles and Responsibilities. She added that the Council should continue implementing the Plan, evaluating the implementation, and looking at changes to be made.

- *Personal Statement from Chata (Ronnie Ashley):* Chata noted that he has spoken at these meetings on behalf of the Council, and said that, at this point, he feels that there have been enough discussions around the RFP process and other implementation issues. He agreed with Valerie that this has been a difficult learning experience. He expressed his sense that the planning parties need now to acknowledge their work, their differences, and their mistakes -- and to continue the work on the Roles and Responsibilities document. He said that the AIDS Office and DPH have expressed their views and explained themselves, and added that the Council and community should not assume that the AIDS Office and DPH are always trying to sabotage them. He stated his belief that the AIDS Office and DPH tried to follow through on the HPPC priorities, and said that it would not help now to continue to fuel the upset over what had happened. Chata emphasized the need to move on and to try to re-build trust and the other necessary elements of the planning process. He encouraged members to keep up their commitment and their participation, and to talk to each other about what is going on for them. While he understood that continuing to participate could be a struggle, he reminded members that it is in their best interests to be able to give input into this process. Finally, he told members that they have a lot in which

they can take pride, and that they still have a responsibility to ensure that the concerns of the community are addressed, and to work on the issues of membership, orientation, and retention -- since a large number of new members will be joining in the coming months.

{**Note:** Isabel and Sacul spoke briefly in response to the statements from Chata and Valerie. Isabel pointed out that it is difficult to think of how to nominate someone for a position on the Council, knowing how much she would be asking of that person (e.g., in terms of the time commitment). Sacul asked about incentives for participation on the Council, and was told that the Membership Committee would be looking into this issue.}

- *Mural and Memorial for Children with AIDS:* Chata announced that Legal Services for Children's HOPE Project and The Precita Eyes Mural Arts Center is having a celebration/ memorial to dedicate the children's HIV mural titled: "We Remember." The celebration of lives will take place on Saturday, November 2nd, from 1:00-3:00pm, in San Francisco's Balmy Alley, between Harrison and Folsom at 24th St. (See enclosed copy of the flyer.)

- *Jobs Needed:* Isabel announced that the Women's HIV Prevention Project is coming to a close, and that three bilingual health educators and one bilingual administrative assistant from the program are looking for new work. Roberto referred Isabel to Ellen's recent announcement of a job available at CAPS (see the minutes of 9/26).

4. PUBLIC COMMENT

Hank Wilson had several items on which he offered public comment, as follows (not verbatim):

⇒ The Council should be informed of the reasons for the disqualification of the two agencies which did not go on to the second stage of review for RFP #016-96.

⇒ Seats on the Council should be filled, through an ongoing and automatic process, as they become open.

⇒ The mention, at the last meeting, of alcohol as a co-factor for HIV transmission was an important comment. There has not been a commitment on the Epidemiology and Research Committee to advocate for the priority of studies on alcohol, as it relates to HIV risk. There is a great deal of information in the 1995 Priority-Setting Chapter on the functioning of poppers as a co-factor, but that section was included largely because Hank Wilson (the speaker) insisted on its inclusion, and provided articles on the topic.

⇒ Some question remains as to how DPH programs are being treated and evaluated, as compared with other prevention programs, which had to submit regular proposals. Does the funding process create a kind of momentum, or is it possible to pull back from programs (such as those put in the 2nd RFP), as the needs for prevention resources shift?

⇒ Voting by fax or phone raises serious procedural questions, which can come back to haunt the HPPC. The Council has at times finalized a decision based on a vote with a one-person difference. Had absent members been polled for those decisions, the outcomes could easily have been different. The acceptance of fax or phone votes for the letter of concurrence raises questions about the consistency and fairness of the approval process.

⇒ Regarding condom distribution in bars, there was an interesting survey recently in the B.A.R. What about free condom distribution in the Tenderloin? Is someone watching what happens in those bars, and taking responsibility for that area? Condom distribution needs to be offered in low-income areas of the city, as well as in the Castro and Mission. (**Note:** Sacul said that Street Outreach Services does have outreach workers that go to the

Tenderloin, and to other low-income areas of San Francisco. She also said that she could bring up the issue of outreach in Tenderloin bars at the next SOS meeting.)

⇒ The Ryan White CARE Council, also called the Health Services Planning Council, keeps a log of how each member votes on each motion. This kind of record (as a kind of procedural mechanism for accountability) might also be valuable for the HPPC.

⇒ It is important for the Council to give constructive criticism. Otherwise, the city is just wasting a lot of money on this process.
(**Note:** Joshua spoke in support of Hank's statements. He especially agreed with the suggestion for an ongoing process for filling member slots, as they open. He said that people who are not attending should be removed from the Council and replaced.)

5. GOALS AND OBJECTIVES UPDATE (no quorum for scheduled voting)
Isabel asked that members review the current draft of the "Goals and Objectives for the 1997 HPPC" for the November HPPC meeting, at which time the document will receive a final vote. She read over the shaded areas (indicating pieces that have been changed since the concept vote discussion) of the 10/8 draft, which was faxed to all members. (**Note:** the newest draft of the document is enclosed with these minutes, and reflects the changes suggested at this meeting.)

Jimmie asked whether the third process objective should be interpreted as meaning that the HPPC Steering Committee would meet only once every two months, or would only monitor progress on the accomplishment of the HPPC goals and objectives every two months (but meet more often). Isabel agreed that this language should be clarified. (**Note from Valerie:** The Steering Committee will actually meet only once every two months in 1997. The scope of this committee's activities will be determined before the next Council year begins.)

Roberto asked that the process objective #5 (i) be revised to show the three levels of evaluation (bulleted), for the actual vote in November. (**Note:** The naming of the three levels of evaluation in the document was postponed, because the Evaluation and Technical Assistance Committee has used different terms at different times for the three levels, and had not yet decided which to use for the Plan.) Roberto also said that he was glad to see the highlighting of the changes to the document. This formatting approach is helpful to members, who may not otherwise notice what is new in a document that they have seen several times.

6. BREAK

7. LINKAGES UPDATE (no quorum for scheduled voting)
Chata reported that the Council's suggestions (offered on 8/22) for the "Recommendations for Referrals and Linkages" document had been incorporated into the 9/5 draft of the document (distributed at the last meeting and, to those who were absent, in the last Council minutes packet). He noted that a successful referral is defined by the committee as one in which the client follows through and receives services at the referral destination. The vote on this document also had to be deferred to the next meeting, for a quorum.

8. MEMBERSHIP UPDATE AND BY-LAW REVIEW
Christine explained that the committee has a new member, in addition to the veteran committee members Jacqueline McCright and Jonathan Brown (who were Council members in 1994 and 1995), and herself and Valerie (both serving on this year's Council).

She informed the group that the by-laws specify a term of office of two calendar years for HPPC members, and they also specify that the appointment of new members should be staggered, so that only one-half of the positions are being filled at one time. However, the Membership Committee is proposing the following changes to the by-laws:

1) **An amendment to allow members to serve two years and an additional two-month initial provisional period, during which they do not vote.** This extension of terms would allow new members to sit on the Council for two months of observation and orientation, prior to the time when they would actually be expected to vote and act as full members. These members would be appointed, then, in November and in June, and would begin serving in their official capacity in January and August, respectively. Even those new members selected to replace members leaving before the end of their terms would serve the full two years and two months. Thus, the staggering of new membership would continue, but orientation to the process could begin for new members before demands are made on them to participate fully and to vote on Council business. A natural mentorship could then be set up between veteran members and their replacements (e.g., they could sit together at meetings). The new members would not be counted for a quorum until January or August, respectively.

2) **An option for members who have served for two years to apply for a second, consecutive term.** This would allow the Council to benefit from the experience of members who have completed one term on the Council. Applicants for second terms would join the regular nominations pool and would receive the same consideration given to other applicants.

3) **The addition of Branch Chief Gene Copello to the by-laws, in the "Conflict Resolution" section.** (This change simply represents an updating of the by-laws to reflect the hiring of Gene Copello as branch chief.)

Joshua said that he likes the idea of a term of two years and two months, since the Council has been experiencing such a lull in participation over the past few months. He added that there is still the problem of people joining the Council and then not fulfilling their obligations. Christine suggested that part of the difficulty for filling Council positions has been that the selection process is complex, difficult, and time-consuming -- especially because it is hard to coordinate the schedules of everyone on the Selection Committee. As a result, it has not seemed feasible to try to go through the selection process more than twice each year. Valerie responded that the selection process has been difficult in the past, but that it doesn't necessarily have to be difficult. Once everyone on the Selection Committee is able to meet, the process moves relatively quickly. However, when the selections are made, there is still the challenge of trying to put together an orientation and gain the new members' commitment to attend. Joshua noted that the one-on-one mentorship would help with the orientation of new members.

Chata said that the Membership Committee had already begun to talk about the selection process, orientation, and incentives for new members. Joshua stated that, ideally, people would join the Council and would not have to leave before the end of their terms. However, he felt that the Council should be prepared for the eventuality that people will leave their spots prematurely. Bethsaida asked whether the Selection Committee could **select more Council members than are needed to fill the available seats**, and orient all those selected at the same time. This would leave a group of alternates, who could then be asked to take the place of members leaving before the end

of the term. Ana Claire responded that the Selection Committee had attempted this system during the last process, but that the system of alternates requires actually selecting twice as many members as are needed, so that each member in the backup group reflects the same experience, expertise, and community ties as the member that he or she could be replacing. The requirements for representation on the Council are very specific, and it could be difficult to find, at any one time, two people who fulfill the requirements for each seat.

Jimmie expressed his support for the term of two years and two months. However, he had some concern about the situation for mentorship at the end of this year and beginning of next year, since there might not be enough continuing members to mentor all of the new members. Christine said that, to her knowledge, twelve positions were currently vacant, and five more members would finish their terms at the end of December. This leaves 17 spaces for new members, on a Council that has 37 members when it is full. Ana Claire and Jimmie noted that these numbers didn't sound right to them (in that more than 12 positions seemed to have been vacated already). Isabel pointed out that perhaps only 12 people had officially resigned, but that the mentors not only would have to serve as nominal members of the Council, but would have to be present to do the mentoring.

Ana Claire asked whether any changes were being recommended to the conflict resolution section (Article IX, Section 1) of the by-laws. She received clarification that this section would be changed only through the addition of Gene Copello, who serves as the link between the Council and AIDS Office Director Mitch Katz. Ana Claire then mentioned an issue for the Membership Committee to consider in the future. She explained that she had not planned to serve longer than two years, and that she could not guarantee that she would be around for the first quarter of the 1997 Council. She offered the following suggestion:

- Select a member who has been serving on the Council for one year, to serve another two years as co-chair. Then the co-chair can get his or her bearings during the first year of membership, and, as a result of this experience, can contribute more to the Council in the following two years. If the person is able to plan for a **three-year term**, then it should not be difficult for him/her to stay on as needed, and to keep that continuity between Councils.

Chata expressed support for Ana Claire's idea; he agreed that it is difficult to learn how to function in this Council, and that it takes some time to be ready to participate fully. He then spoke as a person with HIV, and said that he has had questions about disclosure and other HIV status-related issues that come up for him on the Council. He explained that it is not easy for those on the Council who are HIV-positive to dive into the culture, focus, and atmosphere of the HPPC. Membership requires a particularly large commitment for those who are dealing with illness. Chata said that the Council does need to work on supporting those individuals who are living with illness, and to recognize that it is difficult for many of them to disclose their situations, to seek support at the Council, and to talk about their health issues. He added that sometimes these individuals feel burdened once they do put themselves on the line by talking about their situations.

Jimmie noted that, currently, the by-laws allow for the possibility of a member serving a second term on the Council, after one year of absence. Referring to the two recommendations of the Membership Committee, he summarized that a member could be brought on for a term of two years and two months, and then have that term extended for another two years. He added that, if someone is selected for the community co-chair position after one year of his or her second term as a member, and is asked to serve for another two years as co-chair, then that person could sit on the Council for a total of five years (and two months). Jimmie suggested that some provision should be made to prevent an abuse of the extended terms. Lyn clarified that people would not be able to

extend their own terms -- they would only be able to re-apply, and the Selection Committee would then decide whether or not to extend their terms. (**Note from Valerie:** This issue requires further discussion and clarification, and will not be included in this round of changes to the by-laws.)

Sacul asked why, if someone has been active and committed in serving on the Council, that person should have to apply, along with everyone who has not yet done anything for the Council. She suggested that people who have already devoted their time and energy to the Council should be given some special consideration, at least in the form of a space on the applications that allows people to describe prior experience on the Council. Sacul added that she had been completely confused for the first three months of her term, and that she still feels that she needs a mentor. She has been taking her questions (regarding terminology, for example) to a co-worker. She said that, despite these difficulties, she had committed to her role as a member. She described the suggested term of two years and two months as an excellent idea. Ana Claire responded to Sacul's first point, by saying that the Council cannot simply extend terms without repeating the application process, because of concerns expressed in previous years about the problems that could result if everyone extended his or her membership. Should members be allowed to extend their own terms, the Council would become more like an exclusive club, with an emphasis on experience supplanting the emphasis on staying current. She explained that, in the past, members could not re-apply to serve a second term at all. The Membership Committee is exploring ways of improving continuity between Councils at this point, because some of the problems of the Council may be related to an imbalance in the direction of having too much change with each new year.

Liz stated that she appreciated the suggestion of a pool of alternates for the new members selected. She explained that the turnover of seats on the Council seems to happen rapidly, and added that the possibility of a three-year term, or of re-application after one term, should be explored. Finally, she expressed concern that the small group of members remaining might not have the time or energy to do all of the mentoring that will be required.

Terry noted that mentoring relationships ask a great deal of both partners, and compared the pressure to that experienced by people moving in together. She wondered what would happen if one person in the mentoring relationship wanted to leave the Council. Terry stated her agreement with the idea of using alternates. She also echoed Sacul's point about needing mentoring, and having been lost for some time after joining the Council.

9. RESOURCE INVENTORY UPDATE (no quorum for scheduled voting)
Jimmie asked members to review the updated drafts of the resource inventory recommendations, and to call or fax him with any major changes or other input. He explained that, if people have major changes to suggest, the committee will have to call another meeting to discuss them before the next Council meeting.

Valerie explained that there are some limitations on the way that the resource inventory can be presented for 1996, and even for 1997 (though to a lesser extent). She recommended that members tell Jimmie what they would like to see in the resource inventory (if they don't see it there already), so that Jimmie can say whether it can or cannot be done for that year. The differences in data collection and reporting requirements between contracts for 1996 and those for 1997 allowed for a more detailed and informative design for the 1997 resource inventory, which will also be better able to reflect the HPPC categories and priorities.

Enclosed with These Minutes (for all members):

- Copy of the flyer for the dedication of the children's HIV mural: "We Remember"
- New (10/28/96) draft of the Goals and Objectives for the 1997 HPPC
- Copy of the HPPC by-laws, with underlining and strike-throughs showing the changes proposed by the Membership Committee
- Updated (10/28/96) calendar of HPPC-related meetings for November

Enclosed with These Minutes (for those absent):

- Letter of HPPC concurrence with the AIDS Office application to the CDC, and attached statement of HPPC concerns
- "Resource Inventory Recommendations for 1996, 1997, and 1998"
- "Key for Resource Inventory" and Resource Inventory Matrices for 1996
- "Evaluation Results" and "Participant Dialogue" boxes for 9/26

Next Meeting:

- Thurs., November 14, from 3-6pm at the First Unitarian Church (1187 Franklin @ Geary)

Please Read and Bring (for important voting items that require immediate attention):

- Minutes of 9/12, 9/26, and 10/10;
- New (10/28/96) draft of the Goals and Objectives for the 1997 HPPC;
- "Recommendations for Referrals and Linkages" (9/5 draft, distributed at 9/26 meeting);
- Membership Committee's recommended revisions to the by-laws;
- RA/RI Committee's revised resource inventory key, matrices, and recommendations; and
- Any other relevant committee minutes or attachments (to committee or Council minutes).

Minutes Recorded by: Mary Irvine
Minutes Approved by: Co-chairs Valerie Kegebein and Chata (Ronnie Ashley)

HIV PREVENTION PLANNING COUNCIL MEETING

November 14, 1996
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

Please read: Agenda, minutes of September 12 and 26, October 10, Goals & Objectives, Linkages Report, Resource Inventory, and revised By-Laws (sent to you previously)

***Please bring*:** Entire Package

Agenda

1.	Welcome & Introductions	Ana Claire Meyer	3:00 - 3:05 PM
2.	Minutes from September 12, 26, & October 10	Ana Claire Meyer	3:05 - 3:15 PM
3.	Steering Committee Report	Chata	3:15 - 3:20 PM
4.	Announcements	Ana Claire Meyer	3:20 - 3:30 PM
5.	Public Comment	Ana Claire Meyer	3:30 - 3:50 PM
6.	Goals & Objectives - Adopt	Barbara Adler	3:50 - 4:00 PM
7.	Linkages - Adopt	Chata	4:00 - 4:10 PM
8.	Membership/By-Laws - Vote	Christine Edwards	4:10 - 4:40 PM
9.	Break		4:40 - 4:50 PM
10.	Resource Inventory - Adopt	Jimmy Naritomi	4:50 - 5:00 PM
11.	Plan Outline	Lyn Paleo	5:00 - 5:15 PM
12.	Invitation for Closure	Ana Claire Meyer	5:15 - 5:25 PM
13.	RFP Update/DPH Program Review	Gene Copello/Brian Dobrow	5:25 - 5:40 PM
14.	Procedure for Researchers' Letter of Support	Epi Research Committee	5:40 - 5:50 PM
15.	Meeting Evaluation	Ana Claire Meyer	5:50 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - December 12, 1996.

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Dept of Public Health

HIV PREVENTION PLANNING COUNCIL
MINUTES
November 14, 1996

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Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Isabel Auerbach
Christine Edwards
Roberto Garcia
Ellen Goldstein
Natalie Gutierrez
Liz Highleyman
Sacul L'Adnbre
Ana Claire Meyer
Jimmie Naritomi
Mark Peppler
Bethsaida Ruiz
Joshua Volle

Polaris, Inc./Harder + Co.:
Mary Irvine
Lyn Paleo
Eden Tanovitz

Members Absent:
Hector Carrillo
Patrick Forte
Valerie Kegebein
Terry Ryan
Sandy Simms
Gregory Walker

AIDS Office Staff:
Kristen Clements
Gene Copello
Brian Dobrow
Mike Pendo

Guest:
Stacey Vogan, HIV/STD Prevention Training Center
Lidia Mena-Hermida, MNHC, Eval./TA Committee

Process Evaluation Team:
Pali Basi
Ruel Caneda
Cathleen Farrell
Christina Goette
Kevin Roe

1. WELCOME & INTRODUCTIONS

Co-chairs Ana Claire and Chata convened the meeting shortly after 4:00pm, at which time a quorum was present. Valerie was out of town, participating in the external review of Cooperative Agreement applications for the CDC. Those present introduced themselves in order around the room.

2. MINUTES APPROVAL (9/12, 9/26, & 10/10)

The minutes for the past three HPPC meetings were approved, with one exception to the 9/26 minutes: Isabel noted that, while she was paraphrased as having said that she was unsure whether there would be an HIV epidemic among women in San Francisco (p. 11 of the minutes), what she meant was that she was unsure whether San Francisco would see a **growth** of the existing epidemic among women.

3. STEERING COMMITTEE REPORT

Chata provided a brief report on the last Steering Committee meeting. At the meeting, the committee decided to present the Council with a choice about whether to ask Dr. Katz to attend an upcoming Council meeting in December, January, or outside of the scheduled HPPC dates; and which topics to select for that discussion. The Evaluation Team prepared and distributed (at this meeting) forms to collect this input from members present.

The committee also decided to schedule a presentation on parliamentary procedure, to be made by one of the Evaluation Team members at the December Council meeting. This meeting will also include the HPPC end-of-year/holiday party, which will be a potluck affair. If Dr. Katz is not asked to come and discuss implementation issues in December, then there will be more time allotted to this social event.

Finally, the Steering Committee members agreed to invite other Council members to join them in serving on a short-term Roles and Responsibilities Task Force, to prepare this process-related document in December and January. The timeline for this task will require the completion of a draft by the end of January. (Please see the yellow invitation sheet, enclosed for those absent.)

4. ANNOUNCEMENTS

- *Kevin* announced that the pink questionnaires about scheduling a discussion with Mitch Katz would be collected and tallied during the meeting. He added that the Evaluation Team had planned to give members at this meeting an expanded exit survey, but there was no room for this on the agenda. Instead, the evaluators will mail out a survey to all remaining Council members, who will be given reminder calls (if necessary) about returning completed surveys.

- *Joshua* announced that Stacey Vogan had joined the staff at the HIV/STD Prevention Training Center, as a technical assistance person. She will be helping to translate planning information to the community of providers. She comes from New Orleans, where she worked at the AIDS Educational Training Center. Joshua added that she would become especially involved in assisting agencies to meet the requirements for provider-level data collection and evaluation (e.g., the Behavioral Risk Assessment), and he encouraged members of the Evaluation and TA Committee to speak with Stacey.

- *Ana Claire* announced that the Membership Selection Committee had met and had made selections, which were then submitted to Dr. Katz, who (at this time) still had to approve them. Ana Claire noted that the aim was to have the new members present at the December and January meetings (depending on whether the two year and two month term amendment to the by-laws was adopted by the Council at this meeting). Ana Claire stated that there were still some open slots: two for HIV-positive individuals, one for a young person, and one for an SFUSD (San Francisco Unified School District) person. She asked that people keep in mind any additional nominations that they were unable to submit in time for this selection process. More members may need to be selected to fill gaps after January.

- *Ana Claire* also announced that Patrick Forte had planned to attend this meeting, but had been severely physically bashed at a safe-sex event in Oakland. A card for Patrick was passed around the room, for members to sign.

- *Ana Claire* reported that the co-chairs had made preliminary contact with the HPPC's national training and technical assistance resource people. Communication with these support providers will continue, in an effort to resolve how they can help the HPPC (e.g., with the Roles and Responsibilities document, and with facilitation of discussions between the Council and Dr. Katz). Ellen suggested that support also be requested around

membership retention. Ana Claire added that the co-chairs would also try to put into place some ongoing HPPC process for troubleshooting and working out procedural issues.

- *Ana Claire* announced that she had attended a planning meeting for the Co-Chairs Summit (an opportunity for skills-building and information-sharing). She said that pretty much everyone in attendance expressed that their local planning groups were having similar issues around the implementation of resource allocation, and around membership retention.

- *Ana Claire* informed the group that both Zwazzi Sowö and Ed Zold had resigned from the Council since the last meeting. This leaves the membership at 20, until new members join.

- *Ana Claire* explained that she had been feeling burnt out and unhelpful at the last HPPC meeting, but that she was feeling better now, and more hopeful about the year to come. She has decided not to resign in February, but to stay on for as much of the next year as she can.

5. PUBLIC COMMENT
No public comment was submitted at this time.

6. GOALS AND OBJECTIVES -- Committee Chair Barbara Adler
Barbara presented the new (11/13) draft of the Goals and Objectives for the 1997 HPPC (faxed to all Council members on the day before this meeting). She explained that most of the changes had been presented and voted on before, but that the committee had made some minor revisions at its last meeting, mostly for the purposes of clarification:

- Outcome Objective #3 (successful referral): "100%" changed to "90%," to make the objective more realistic
- Impact Objective #1 (third bullet, on the BRA): re-worded for clarity
- Impact Objective #4 (successful referral): added as an interim objective (for the end of 1998)
- Process Objective #3 (Steering Committee): re-worded for clarity (Valerie had verified that this committee would meet only meet once every two months in 1997.)
- Process Objective #5 (work of the individual commitees):
    - (d): given a more realistic timeline
    - (f): date changed (to a month earlier) to reflect the CDC application deadline
    - (g): date changed (to a month earlier) to reflect the CDC application deadline
    - (i): changed to be more clear and to reflect the particular terms chosen by the Eval./TA Committee

Discussion
Jimmie asked about the two different dates shown for the general HIV Prevention Plan compliance objectives (Impact Objective #2 and Outcome Objective #4). Eden explained that the impact objective is for compliance among AIDS Office-funded San Francisco prevention providers, and should be fulfilled by 7/1/98. Compliance among all San Francisco prevention providers (including those receiving their funding from non-AIDS Office sources) is also an objective of the HPPC, but it cannot be expected to happen as quickly -- so it was given the date, 12/31/03.

Jimmie expressed his concern that it is not strictly within the jurisdiction of the HPPC or of the AIDS Office, to demand compliance of non-AIDS Office-funded prevention providers with the San Francisco HIV Prevention Plan. Barbara noted that this objective had been included in previous drafts of the goals and objectives document, and had not been called into question up to this point.

Joshua echoed Jimmie's concern about Outcome Objective #4 being unrealistic. Ana Claire mentioned that the Council had briefly discussed this objective in the past, and had resolved that, while the outcome objective is not necessarily realistic or enforceable, it represents something toward which the Council can work. The Council wants to encourage compliance in all of San Francisco. Barbara asked whether those concerned about the objective would prefer to re-word it or eliminate it. Joshua and Jimmie suggested re-wording this outcome objective, to say that: "By 12/31/03, 100% of *identified* HIV prevention providers in San Francisco will be *encouraged to perform* HIV prevention activities according to the 1995 HIV Prevention Plan and Plan updates."

Isabel noted that the objective could state that providers will be "*...encouraged and assisted to perform...*". This addition would refer to the Plan-related TA to be delivered in San Francisco. Liz responded that it would be unadvisable to imply that the AIDS Office/HPPC can provide unlimited or high-level TA to all San Francisco providers, whether or not they receive AIDS Office funding. Ellen reported that the Eval./TA Committee had recommended that a number of open workshops be planned, to deal with the major capacity areas in which San Francisco providers require and request assistance in order to comply with the Plan. Ana Claire pointed out that the Council could, at this point, vote on the intention of this outcome objective, without deciding the precise wording to be used. She suggested that the group leave the final wording up to Barbara and Eden, with the understanding that they would take into consideration the points made in this discussion.

Bethsaida mentioned the possibility of simply lowering the percentage of San Francisco prevention providers to whom Outcome Objective #4 would apply. Ana Claire repeated her suggestion that the Council move on with the vote, and leave the details up to Barbara and Eden.

Regarding Process Objective #5(i), Ana Claire asked whether resources were really available to implement all three levels of evaluation. Ellen explained that the Eval./TA Committee chapter describes a plan for the HPPC to provide guidance on the implementation of all three levels. However, the implementation of the second and third levels of evaluation (non-provider-level) will require the use of funds from outside (non-AIDS Office) sources.

The Vote (on the motion to accept and adopt these Goals and Objectives for the 1997 HPPC)

In Favor:	**11**
Opposed:	**0**
Abstentions:	**1**

At the time of this vote, 13 members were present, but Ana Claire did not vote. The motion passed by consensus.

7. LINKAGES -- Committee Chair Chata (Ronnie Ashley)

Chata explained that the Council would be voting on the adoption of:

1) The committee recommendations for referrals and linkages (submitted previously to the Council, as a draft dated September 5th); and
2) The committee's definition of successful referral (which entails a client following through on the referral and receiving services).

The Council agreed that there was no need for discussion of these recommendations.

The Vote (on the motion to accept and adopt the "Recommendations for Referrals and Linkages")

In Favor: **12** (unanimous)

The motion passed by consensus.

The Vote (on the motion to accept and adopt the definition of a successful referral)
In Favor: **13** (unanimous)[1]
The motion passed by consensus.

8. MEMBERSHIP/BY-LAWS -- Committee Chair Christine Edwards
Christine pointed out the cover memo attached to the revised draft of the by-laws (dated November 1, 1996, and mailed to all HPPC members). The cover memo describes each of the recent changes made to the draft document. Because the revised document includes earlier changes not yet voted upon by a Council quorum, Christine was asked to go through each change shown (with formatting) in the document itself. There was also some initial confusion about whether the vote would cover all of the by-laws, or simply the proposed amendments. Ana Claire explained that the vote would refer only to the proposed amendments shown in the current draft, and that any additional proposed amendments would have to be submitted to the Membership Committee, for consideration at a future meeting[2]. Changes to the by-laws require at least a two-thirds majority vote, and the process of making changes requires time to notify the Council of all amendments under consideration. By-law changes cannot be proposed for the first time and then given a vote at the same meeting. Christine briefly noted the amendments receiving a Council vote at this time, and members proceeded to vote on each individual item (with discussion, where necessary):

- Article II, Section 1: Adopt the changes shown (on 11/1 draft), and add the word "evaluate" (an addition suggested by Jimmie at this meeting).
  In Favor: **13** (unanimous)

- Article II, Section 4: Adopt the deletion of "community based," as shown.
  In Favor: **13** (unanimous)

- Article III, Section 1: Adopt the minimum of 30 members for the HPPC to remain operative.

  Discussion
  Members expressed concerns about the realism of a requirement that the HPPC maintain a membership of at least 30 in order to function. They pointed out that the current membership would not satisfy this requirement. Liz noted the time lag for bringing new members onto the Council, and Joshua added that currently there is no amendment to the by-laws that provides for a reserve pool of members (as suggested at the 10/10 HPPC meeting). The group also wondered whether it would be able to meet next month, after adopting the minimum membership requirement. Jimmie proposed that the vote on the amendment be deferred to next year's Council. Ellen added that the eventual vote should specify that the minimum membership must be maintained through mechanisms for retention and renewal.

  The Vote (on the motion to defer a vote on this amendment for the 1997 HPPC)
  In Favor: **9**
  Opposed: **4**

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[1] At this point in the meeting, Mark Peppler, a Linkages Committee member, arrived and gave his vote.
[2] Joshua mentioned his intention of proposing a change to Article IV (Sections 1-4), in the number of nominations solicited for different types of representatives on the Council. He advocated for setting aside more seats for non-governmental and community representatives, and fewer seats for governmental representatives and technical experts. He will submit this suggestion to the Membership Committee.

Abstentions: **0**
The motion to defer carried, by a majority vote.

- Article IV, Section 1: Adopt the change to include the Chief of the Prevention and Health Programs and Policy Branch of the AIDS Office as a non-voting ex-officio HPPC member.

Discussion
Joshua identified a conflict of interest involved in the addition of the Branch Chief (Gene Copello's position) as a member of the HPPC, as well as a first level arbitrator (see the proposed amendment to Article IX, Section 1). Gene responded that, as an ex-officio member, he would not vote, and so would not actually have any power to set policy through the HPPC. However, he felt that his presence at the table would be important. Ana Claire echoed Joshua's concern about having the Branch Chief fulfilling this dual role as member and arbitrator. She felt that the Council should choose to have Gene serve in one or the other of the two roles. Ellen spoke up to say that she thought it had hurt the Council not to have Gene involved earlier in the planning process. She believed it would help to have Gene at meetings and participating in any arbitration. Mark and Jimmie expressed agreement with Ellen, stating that checks and balances of power are already in place (e.g., Gene would not vote as a member, and others would be involved in the arbitration process as well).

The Vote (on whether to include the Branch Chief as a non-voting ex-officio HPPC member)
In Favor: **12**
Opposed: **0**
Abstentions: **1**
The motion passed by consensus.

- Article IV, Section 2: Adopt the addition of language specifying the role of the Unit Chief (Valerie's position) in soliciting technical experts for membership. (Gene clarified that "Unit" should be substituted for "Section" in this passage.)
In Favor: **12** (unanimous)[3]

- Article V, Section 1: Adopt the change to allow Membership Selection Committee meetings to proceed with two of the three HPPC co-chairs and two of the three Mayor's HIV HSPC co-chairs. (Jimmie asked that the language be revised to clarify that it is just the **co-chairs** of these two Councils that are involved in the membership selection process.)
In Favor: **13** (unanimous)

- Article V, Section 2: Adopt the extension of membership terms to 24 months, plus 2 provisional months, and adopt the change to allow members to re-apply for second terms.

Discussion
Brian read aloud from a memo (enclosed for all members) written by Valerie Kegebein, to communicate her views on some of the agenda items for this meeting, including this proposed amendment to the by-laws. Joshua expressed concern that, in view of the upcoming vote on the requirement for a minimum of 30 HPPC members at all times, the plan to appoint new members in January and August might not suit the actual need for appointments. He

[3] Sacul was out of the room for this vote, and so could not be counted.

suggested striking the language specifying months of appointment. Liz suggested instead that the amendment specify that terms will normally begin in January or August, but that a special provision will be made if and when the Council membership drops below the required number. Christine added that the initial decision in favor of appointments two times per year had reflected a desire to keep a balance of older and newer members, while recognizing the difficulties of convening the Membership Selection Committee to make appointments. Ellen offered support for Liz' suggestion of a special provision and a general rule of two times per year. Roberto agreed, and added that the length of terms should be kept absolutely clear. Sacul wondered how the Council's desire for a mentoring of new members by veteran members could be accommodated by the amendment. Jimmie recommended the deletion of the term commencement dates, in order to maintain flexibility.

The Vote (on the motion to approve the amendment as it stands, with a caveat that the Council will continue to discuss special provisions for filling positions as necessary)
In Favor: **11**
Opposed: **2**
Abstentions: **0**
The motion passed by a majority.

- Article V, Section 3: Adopt the multiple changes shown, and continue to discuss special provisions for filling positions as necessary (same issue as that discussed above).
  In Favor: **13** (unanimous)

- Article V, Section 4: Adopt the change to extend exemptions from absence-related termination to include life-threatening illnesses other than HIV disease.

Discussion
Isabel pointed out that people may have major concerns and illnesses that are not specifically "life-threatening," but that bear heavily on their ability to attend meetings. She expressed her sense that, in some ways, it makes sense to limit the exemption to those living with HIV. At the same time, she wondered whether it would be more helpful in some cases to bring in a new HIV-positive member who expects to be able to participate regularly at meetings. She agreed with the original intention of the exemption, to prevent the loss of representation of people with HIV on the Council. Chata noted that the Membership Committee is also looking at ways in which people dealing with serious illness might be able to do some work for the Council from home. Ana Claire stated that there is a balance in place, in that HPPC members with HIV have had to resign in some cases, and have been able to participate from home in other cases. The proposed amendment would formalize the conditions for exemption from termination. Joshua added that he hoped the Council would not be in a position of having to rely on the participation of a single person with HIV; instead, people with HIV should be well enough represented on the Council as to allow for some absences.

The Vote (on the motion to extend the exemption clause to other life-threatening illnesses)
In Favor: **12**
Opposed: **0**
Abstentions: **1**
The motion passed by consensus.

- Article VII, Section 5: Adopt the lowering of the threshold for a quorum, from more than 50% of the current membership, to just 40% of the current membership.

Discussion
Joshua expressed his discomfort with this measure for ensuring regular achievement of a quorum. He suggested that the Council work on addressing the reasons for members' absences, rather than making it easier for business to proceed despite heavy rates of absence. Jimmie also stated his opposition to the amendment, explaining that he knows of no other official voting body on which a motion can pass without at least a simple majority. Ana Claire read a statement of Valerie's support for the amendment, from the larger memo submitted by Valerie to be referred to in her absence. Chata agreed with Joshua that the Council should address the problems causing absences, rather than lowering the quorum. He felt the larger issues around membership attrition and inadequate participation would not be addressed with this amendment. Joshua suggested that, rather than pass the amendment, the Council might look into other potential mechanisms for voting. Sacul spoke in favor of absentee ballots. Ana Claire responded that any amendments providing for alternative methods of voting would have to be proposed to the Membership Committee, for planned discussion at a future Council meeting.

The Vote (on the motion to approve a lowering of the quorum to 40% of the membership)
In Favor: **0**
Opposed: **13** (unanimous)
The motion failed.

- Article VIII, Section 1: Adopt the addition of the words: "and implement," as shown.
In Favor: **12** (unanimous)[4]

- Article IX, Section 1: Adopt the clarification/updating of AIDS Office branch names, unit names, and titles (for Gene's and Valerie's positions); and adopt the addition of the Prevention and Health Programs and Policy Branch Chief (Gene Copello, in this case) as the first level arbitrator for conflict resolution.

Discussion
Ana Claire reiterated the discomfort that she and other members had expressed in the earlier discussion of the addition of Branch Chief (Gene Copello) to the total HPPC membership. She opposed the dual positioning of the Branch Chief as first level arbitrator *and* member. She added that she has concerns about the functioning of the current arbitration system for the HPPC. Joshua said that he didn't see the necessity of having Gene serve as a formal arbitrator, when he is present and contributing to the HPPC meetings as Branch Chief. Sacul asked why, in a community-based process, there was so much power coming from the AIDS Office; she wondered why the HPPC could not have a CBO arbitrator position. Jimmie pointed out the need for a comma following "the HPPC" and preceding "its co-chairs," in the second line of the passage (to clarify the flow and meaning of the sentence). Ellen suggested the addition of a mention of the CDC project officer to the HPPC, as a partner in the conflict resolution process. She felt that the by-laws should reflect the presence of that person as a resource to the Council. She added that the omission of a mention of the CDC project officer contributes to a sense of the HPPC's isolation and

[4] One member was out of the room at this point.

powerlessness in any conflicts arising. Mark proposed that, at a later opportunity, the Council might vote on this specification of the project officer role -- in Article IX, Section 2.

The Vote (on the motion to adopt the current title/branch/unit language and the addition of Branch Chief as first level arbitrator)
In Favor: **0**
Opposed: **8**
Abstentions: **5**
The motion failed. The Membership Committee will continue to work on the amendment of this portion of the by-laws, and will take written suggestions faxed by members to Lyn Paleo or Christine Edwards.

At this point, having individually reviewed all proposed amendments to the by-laws, the Council proceeded to a vote on the adoption of the **total set of current by-laws, as amended today** -- with the note that further discussion will take place on ways to address membership attrition and on the mechanisms for arbitration (and that further amendments may be proposed to the Membership Committee, and then scheduled for future Council discussion and voting). Prior to the actual vote, Gene pointed out that the CARE Council (Mayor's HIV HSPC) has no formal mechanism for including the input of the HPPC on new member selections. He suggested that this incongruity between the two HIV-related planning bodies be considered as an issue for future discussions of the by-laws of each council.

The Vote (on the motion to adopt the by-laws, as amended, with the caveat that some issues have had to be tabled for future Council discussions)
In Favor: **13** (unanimous)

9. BREAK
(Christine Edwards left the meeting during the break, so there were 12 members remaining to vote on the following items.)

10. RESOURCE INVENTORY -- Committee Chair Jimmie Naritomi
Jimmie referred to the draft documents (dated 10/4 and 10/10) distributed at the last Council meeting (and mailed with the minutes to those absent). He explained that the Council would be voting (1) on the resource inventory design for 1996 and (2) on the resource inventory design for 1997, 1998, and beyond. He noted that the 10/10 draft of the key includes a change, under **Interventions**, to the definition of CTRPN: it now says "CTRPN = *Confidential* Testing, Referral, & Partner Notification." Jimmie added that the detailed tables shown for 1996 should be understood as **sample** tables at this point, since not all information is yet available on 1996 contracts. The Council vote relates only to the design of the tables (the type of information to be included and its format), and not to the specific contents.

Discussion -- Resource Inventory Design for 1996
Ana Claire suggested the inclusion of a caveat that, next year, non-AIDS Office-funded providers would be included in the resource inventory. Jimmie explained that this issue had been discussed in the last committee meeting, and that AIDS Office staff had explained that the RFP process started at ground zero, meaning that it did not take into account any potential sources of non-AIDS Office funding. He added that it was not yet possible to do a resource inventory of all non-AIDS Office-

funded providers for 1996. He asked that this question of the caveat be deferred to the discussion of the 1997 resource inventory.

Ana Claire also noted that the committee had been told that estimates could be obtained for the total 1996 funding amounts by ethnicity served, but that they could not be obtained until early 1997. She requested that this information on 1996 contracts be included in the next update to the Plan, for the 1996 resource inventory summary tables, and added that the current issue of the Plan should include language to reflect that this information (for January to December, 1996) will be coming in the next issue. She reasoned that it would be helpful to have these estimates later, for the purposes of comparison with the contract years following 1996. (Voting on Ana Claire's suggestions was postponed for the 1997 resource inventory piece.)

Chata asked whether the committee had reached some definition of "multi-ethnic" (a term used in the *covariates* and/or *provider-defined target population* columns for some of the agencies in the 1996 resource inventory). Jimmie responded that, at some point, the Council will need to define this term, and the requirements of agencies to be described as serving a "multi-ethnic" population. He explained that setting such a definition did not necessarily seem to be a task for the Resource Allocation & Resource Inventory Committee, especially within the given time frame for these recommendations. Ana Claire added that one of the committees for the 1997 HPPC would be assigned the task of defining "multi-ethnic" client populations.

The Vote (on the motion to approve the resource inventory charts for the end of 1996)

In Favor:	**11**
Opposed:	**0**
Abstentions:	**1**

Discussion -- Resource Inventory Design for 1997, 1998, and beyond...
Ana Claire noted that her suggested addition (of a note that the resource inventory for non-AIDS Office-funded prevention resources will be compiled for 1996 contracts, and added to the next version of the Plan[5]) should be made to page 1 of the 10/4 draft of the "Resource Inventory Recommendations..." document. She reiterated her point that summary charts showing the total funds by ethnicity and by age should be provided for January-December 1996 contracts and July 1996-June 1997 contracts, as soon as that information becomes available. Mike confirmed that the AIDS Office could produce retrospective charts on the 1996 and 1996/97 contracts, in 1997 (about three months after the end of each contract period).

The Vote (on the motion to approve the charts for 1997, 1998, and beyond -- with the plan to include non-DPH contract information for 1996, and to include retrospective summary charts for 1996 and 1996/97 contracts, when this information becomes available)
In Favor: **12** (unanimous)

As a result of this vote, a sentence will be added at the end of p. 1 of the recommendations document: *"For a Plan update in 1997 and beyond, a resource inventory will be compiled for prevention activities funded through sources other than SFDPH."* The first page of the revised recommendations document will also state that, for January-December 1996 (CDC), and July

[5] The resource inventory tables for non-AIDS Office contracts may appear somewhat different from the tables designed for AIDS Office contracts -- since the standards of data collection and reporting, as well as service categories and population categories, may not match those required of AIDS Office contractors.

1996-June 1997 (State and General funds) contracts, *the resource inventory for the end of 1997* will provide rough estimates for charts 2 and 4 (i.e., age and ethnicity).

With both motions passed by consensus, Jimmie acknowledged the hard work and patience of the committee and the Council in completing this difficult task. He added that the committee did not plan to meet again this year. Chata and Ana Claire acknowledged the complexity of this committee's work, and thanked Jimmie for his service as the chair.

11. INVITATION FOR CLOSURE -- MEETING WITH DR. MITCH KATZ
Briefly, Kevin Roe summarized the results of the survey on members' needs for a discussion with Dr. Katz. Of the fourteen members responding at this meeting:

⇒ 12 members wanted an opportunity to meet again with Mitch Katz.
- ° 2 preferred to put this discussion on the December meeting agenda.
- ° 3 preferred to put this discussion on the January meeting agenda.
- ° 7 preferred to hold a special meeting for the purpose of having this discussion .

(One person responded that this meeting should take place in December, specifically.)

⇒ 2 members responded that they did not need an opportunity to meet again with Mitch Katz.

As a result of this survey, Dr. Katz will be asked back to the Council in either December or January. The specific meeting time will have to be decided, and members will be informed as soon as possible. Already at the December meeting, the Council will be gaining 16 new members, voting on the adoption of the Plan, and having the end-of-year party. Dr. Katz has received a full report on all RFP-related concerns expressed up to this point. Any other specific concerns that members wish to have addressed at the meeting with Dr. Katz should be submitted to him directly.

Ana Claire read Valerie's statement on meeting with Mitch Katz (see the page with her comments).

12. RFP UPDATE / DPH PROGRAM REVIEW -- Brian Dobrow
Brian reported that the technical review panels (consisting of community representatives and HPPC members) had met in mid-October, to look at 29 proposals, including:

- 11 for CTRPN;
- 8 for Venue-Based Individual Outreach (VBIO);
- 8 for General Education;
- 1 for Condom Distribution; and
- 1 for Provider Training.

AIDS Office program managers and planning staff met twice to go over the recommendations of the review panels, and to consider the final distribution of funds to approved providers. Their recommendations were submitted to Gene Copello and Dr. Katz, for their consideration and approval. At the time of this meeting, Mitch had not yet reached a final decision. However, his decision was expected to be released (finalizing this round of awards) by the end of this week (November 15th, at the latest). Brian said that the award letters would then be faxed out on November 15th or 18th.

Barbara pointed out that the delays in finalizing the awards would seem to cause difficulties for those providers expected to begin their new contracts in January. Gene responded that the AIDS Office would expedite the contracts as much as possible. Jimmie supported Barbara's point,

saying that it would seem impractical to expect that contracts could be developed and ready to begin by January 1st, as scheduled. He asked if the AIDS Office would consider doing retroactive contracts. Gene responded affirmatively. He added that there has been a streamlining of the contracts process, and that the Contracts Unit is now a part of the Health Services and Prevention Unit. These changes should allow contracts to be formed more quickly.

Ellen and Natalie spoke briefly as HPPC members who had served on the review committee for DPH scopes of work. Natalie and Ellen agreed that the AIDS Office was very responsive to the suggestions and critiques that they offered on the DPH prevention providers' scopes of work. Natalie added that she appreciated having been asked to participate in the review process, and appreciated the presence of contract managers at the review meetings. Jimmie said that he was glad to see that this process for input from HPPC members occurred, because it represents a mechanism for DPH accountability.

13. PROCEDURE FOR RESEARCHERS SEEKING HPPC LETTER OF SUPPORT
Liz spoke as the current chair of the Epidemiology & Research Committee. She explained that the committee had reviewed possible procedures for letters of HPPC support, and had decided that the procedure should not be bound to any single committee -- since the organization of 1997 committees may not resemble their current organization. She distributed the committee's proposal for a procedure (enclosed for those absent), and members present took a moment to read it over.

The Vote (on the motion to adopt the proposed procedure for letters of HPPC support for research)
In Favor: **12** (unanimous)

14. PLAN OUTLINE -- Lyn Paleo
Lyn reported that she had received all drafts of the chapters from writers outside of Harder + Co. Harder + Co. was, at the time of this meeting, still in the process of reviewing some chapters. Lyn explained the intention to make the Plan as accessible as possible, to the differents groups of audiences likely to be reading it. To increase this accessibility, a guide on how to use the Plan will be included in the overall Introduction. Lyn added that the chapters are being written to be nearly stand-alone narratives. However, the chapters will also refer to one another in certain places. (These cross-references will also be explained in the general Introduction.) The Plan will include a user-friendly index at the back, as well. Lyn stated that the full Plan will be sent out from Harder + Co. to reach the Council membership on December 4th, in order to give people a chance to read it through sequentially. She asked that any members who do not have time to read the entire Plan prior to the December 12 vote select those areas of greatest interest to them, for a close review. **(Note:** The Outline of the San Francisco HIV Prevention Plan is enclosed for those absent.)

Discussion
Chata commended the writers on the Plan for the work that they have done. He said that his only critical comment at this point is that much of the process and passion behind the work of the HPPC seems to have been left out of the Plan narrative. He expressed his disappointment with this omission of the process (struggles, difficulties, group interactions, and problem-solving) by which the HPPC produced its guidance. Lyn responded that she expected that this kind of process information would be included in Kathleen Roe's separate process evaluation report, and that its inclusion in the Plan would have made the Plan so long as to be overwhelming for potential readers. The primary purpose of the Plan is to record the products of the HPPC work, as well as the basic procedures for decisionmaking on those products.

Speaking as one of the evaluators on Kathleen Roe's team, Kevin said that the information on the HPPC process will go into the evaluation report, which should come out in January. Chata said that he wanted this information to be made available to future Councils and to other planning groups, which could learn from the experiences of the HPPC. Kevin said that the process would be recorded, along with the evaluators' recommendations, but that it was then up to the planning groups to decide how to use the information. Barbara agreed with Chata's point about the importance of the process piece. She suggested that perhaps some summary of the process could be included in the conclusion (the "Wrap up and Future Directions" chapter) of the Plan. She explained that she didn't think the process should take up an entire separate chapter, however. Joshua expressed his concern that too much information on the process could confuse providers. He felt the Plan should illustrate how planning processes should work. Mark suggested that the Plan could simply reference the process evaluation report. Kevin pointed out that the report is largely intended for the HPPC members to read, and not for use in relation to the Plan. Jimmie reminded the group that the HPPC evaluation of the resource allocation/RFP process is scheduled to occur next year, and that this should also generate the kind of information that is lacking in the Plan.

The meeting was adjourned shortly after 6:00pm.

Enclosed with These Minutes (for all members):

- Valerie's Proxy Correspondence to HPPC, relating to votes taken in her absence
- "December Calendar for HPPC and Related Committees," updated 11/21/96

Enclosed with These Minutes (for those absent):

- Invitation to join the Roles and Responsibilities Task Force
- "Recommendations for Researchers' Letters of Support from Council"
- Outline of the San Francisco HIV Prevention Plan
- "Evaluation Results" and "Participant Dialogue" for the 10/10/96 HPPC meeting

Next Meeting: Thursday, December 12, 3-6pm, at the First Unitarian Church (1187 Franklin St.)

Minutes Recorded by: Mary Irvine
Minutes Approved by: AIDS Office staffperson Brian Dobrow

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HIV PREVENTION PLANNING COUNCIL MEETING

December 12, 1996
3:00 PM to ???
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

Please read: **Agenda, minutes of November 14, and revised Prevention Plan (sent by Harder + Co.)**
***Please bring*:** **Entire Package and Revised Plan**

Agenda

1.	Welcome & Introductions - New Members	Chata	3:00 - 3:20 PM
2.	Minutes from November 14	Chata	3:20 - 3:25 PM
3.	Announcements/Steering Committee Report	Ana Claire Meyer	3:25 - 3:35 PM
4.	Public Comment	Chata	3:35 - 3:55PM
5.	RFP Update	Valerie Kegebein	3:55 - 4:25 PM
6.	Break		4:25 - 4:30 PM
7.	Adoption of Plan	Committee Chairs/Lyn Paleo	4:30 - 5:00 PM
8.	Process Evaluation Report	Kathleen Roe	5:00 - 5:15 PM
9.	Meeting Evaluation	Chata	5:15 - 5:20 PM
10.	Holiday Party	All	5:20 - ???

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

Season's Greetings and Happy New Year!!!

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12/12/96

DPH

HIV PREVENTION PLANNING COUNCIL MINUTES

December 12, 1996

DOCUMENTS DEPT.
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(Key: The asterisk * by certain names indicates new members to the HPPC)

Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Isabel Auerbach
Ahimsa Timoteo Bodhrán*
Hector Carrillo
Gene Copello (ex-officio member, AO)*
Ellen Goldstein
Natalie Gutierrez
Vic Hernandez*
Liz Highleyman
Jelousy Jiggetts*
Valerie Kegebein
Sacul L'Adnbre
Ana Claire Meyer
Askia Muhammad*
Jimmie Naritomi
Dawn Passar*
Joel Reyna*
Maria Rinaldi*
Terry Ryan
Steven Sams*
Sandy Simms
Joshua Volle

Members Absent:
Christine Edwards
Patrick Forte
Roberto Garcia
Jennifer Lorvick*
John Newmeyer*
Henry Ocampo*
Mark Peppler
Bethsaida Ruiz
Gregory Walker

AIDS Office:
Kristen Clements
Lyn Fischer-Ponce
Delia Garcia
Marshia Herring
Tracey Packer
Mike Pendo

Polaris, Inc./Harder + Co.:
Mary Irvine, Polaris
Steven LaFrance, Harder + Co.
Lyn Paleo, Harder + Co.
Eden Tanovitz, Harder + Co.

Guests:
Michelle Aldrich, Drug Abuse Adv. Board
Mike Aldrich, ICHO
Christina Badasow, RAP
Mark Bronnenberg, New Leaf/SOS
Crystal Catamco, A. & P. I. Wellness Ctr.
Brian Cross, TARC
Cynthia Cunningham, Iris
Marilyn Dillihant, SOS
Stephanie Eng, TARC
Dianne Felix, Proyecto Contra SIDA Por Vida (PCPV)
Edwin Florentino, HAFC/SOS
Marjorie S. Katz, RAP
Yvonne Littleton, HAFC/SOS
Lisa McDonnell, ICHO/SOS
Oscar Macias, PCPV
Chente Matus, ICHO/SOS
Skip Menifee, ICHO/SOS
Tony Molina, LCAIS

HPPC Process Evaluation Team:
Pali Basi
Ruel Caneda
Cathleen Farrell
Shiva Memari (observing)
Kathleen Roe
Kevin Roe

Guests (continued from list at left):
Bruce Occena, SFGH
Reginald Reed, HAFC
Lanora Richard, HAFC
Merlenet Riley, ICHO/TARC
Clark Taylor, City College of S.F.
Ann Ueda, LIFE Institute
Adela Vazquez, PCPV
Stacy Vogan, HIV/STD Prev. Trng. Ctr.
Kiki Whitlock, A. & P. I. Wellness Ctr.
Hank Wilson, ACT UP Golden Gate
Dan Wohlfeiler, STOP AIDS Project

1. WELCOME & INTRODUCTIONS -- NEW MEMBERS

Ana Claire Meyer welcomed those present to the meeting, and began the introductions -- for which everyone in the room was asked to state their name, agency, and something that gives them hope.

At the end of this exercise, Jimmie asked for clarification on the number of members required now for a quorum. Until the 1997 HPPC meetings officially begin and the new members begin voting, just 12 voting members must be present to constitute a quorum. At this meeting, 14 voting members were present (though the number of voting members in the room varied over the course of this meeting) -- but Ana Claire did not vote, since she was chairing the meeting.

2. MINUTES OF NOVEMBER 14TH MEETING

The minutes of November 14 were approved without exception. Some extra copies were made available for guests.

3. ANNOUNCEMENTS/STEERING COMMITTEE REPORT

Ana Claire

- Ana Claire welcomed new members present, and explained that some of the new and old members (Mark Peppler, Bethsaida Ruiz, John Newmeyer, Henry Ocampo, and Jennifer Lorvick) had called to notify the co-chairs that they would not be able to attend this meeting.
- The Orientation to the 1997 HPPC is scheduled for January 16th, from 2-6pm. This will serve as an orientation to 1997 tasks, and is intended for both new and continuing HPPC members.
- The January 9th HPPC meeting has been cancelled. The next regular meeting is scheduled for January 23rd, from 3-6pm at 1187 Franklin St.
- The Steering Committee/Roles and Responsibilities Task Force met on Monday, December 9th. In addition to members of the Steering Committee and other members of the HPPC, Nick Farrell of the CDC and Mary Sanchez Baines (the facilitator) attended that meeting. The next two meetings of the Roles and Responsibilities Task Force are now scheduled for January 15th and January 17th. Both meetings will take place from 9am to 1pm at the AIDS Office.

Sacul

- Sacul welcomed the new members and greeted continuing Council members. She spoke for the Street Outreach Services (SOS) collaboration of six partner agencies. She said that SOS has been providing street outreach in 13 San Francisco neighborhoods since 1994. With the last RFP awards process, the funding to SOS was cut by over 80%. Sacul expressed concern that high-risk populations in San Francisco would no longer be reached with HIV prevention outreach services. She announced that a group of people concerned about this situation had met with the Health Commission, which recommended that the DPH investigate the matter and report back to the Commission at its meeting on Tuesday, December 17th.

Isabel

- Isabel noted that she had put out a job announcement (for an outreach worker position) on the table at the front of the room. (A copy is enclosed for those absent, and will also be sent to any others requesting it from Mary Irvine at Polaris, Inc.: 777-3229.)

4. PUBLIC COMMENT

(Notes read during public comment are enclosed with these minutes for all members.)

- *Edwin Florentino of Street Outreach Services* opened by saying that, on the last occasion at which he addressed the Council (July 11th, 1996), he had spoken about street outreach requirements in the new RFP process. The minutes from that meeting reflect Valerie's comments that the units of service document was a contractual document developed by the AIDS Office "from the field notes of CHOWs in San Francisco," and that it was "not intended to dictate how CHOWs do what they do" (from the minutes of July 11th). Edwin described these comments about the document as untrue, and said that they represented a practice of basing public health and funding policies on false pretenses. He stated that there was widespread distress about the RFP process. He noted that, in the Bidder's Conference, applicants were told that they could not apply for Venue-Based Individual Outreach (VBIO) in response to RFP #015-96. Applicants were also informed that an agency's recruitment of clients for its services would not be counted as Venue-Based Individual Outreach, for RFP #016-96. He said that this misinformation represented a deliberate sabotage, and he asked the Council to support SOS and the Health Commission.

  {<u>Notes from Valerie:</u> **(1)** The Unit of Service (UOS) document is used in developing contracts, and the descriptions of UOS are for payment of deliverables. Many logs and field notes were gathered by the AIDS Office, and the resulting "Recommendations and Requirements" section of the UOS document reflects the essential elements of interventions as practiced by various prevention providers. **(2)** VBIO was allowed as an intervention in RFP #015, as long as it met the requirements of the Strategies and Interventions description, and as long as it was part of a continuum of prevention interventions either proposed or provided by the agency submitting a proposal. It was not allowed to be proposed as participant recruitment only. The AIDS Office added VBIO as an acceptable intervention under RFP #015 at the Bidder's Conference, in response to HPPC members' extreme disappointment in the AIDS Office for not including VBIO as part of the BRP-based RFP.}

- *Chente Matus of SOS* called himself the oldest CHOW both in time and in age. He stressed that outreach does not just involve materials distribution, but it requires credibility, trust, and respect. He said that a coalition rated as one of the best in the United States (SOS) could not just be replaced. His concern was not only for the loss of CHOW jobs, but for the clients that would be dropped as a result of the severe funding cuts to the collaboration. He added that unforeseen costs and other logistical problems would be incurred in this attempt to re-form a street outreach coalition. In closing, he told the Council that staff from CAL-PEP had approached TARC staff, to ask where they should do outreach in the Tenderloin, and who would train them. He urged the Council and AIDS Office to see that the SOS collaboration be continued, and to follow the recommendations of the Health Commission.

- *Brian Cross of TARC* said that the concern of TARC staff and of other collaboration members is that the SOS collaboration is the one that worked. SOS CHOWs established rapport with people on the street, and were able to involve them in prevention. Brian clarified that he was not talking about recruitment of clients into a program. He said that SOS had been hitting parts of the Tenderloin that need street-based services, and that, in some cases, CHOWs were putting their lives on the line in order to deliver prevention services. Brian stated that he was concerned about mistakes in the RFP review process, and he asked the Council to support the Health Commission's recommendations. He added that

the AIDS Office is extremely busy, so that it appalled him that they would propose to run a consortium themselves -- especially when SOS has been running one for years.

- *Marjorie Katz of RAP* also stated her concern about the outcomes of the RFPs. Asking the Council to keep in mind that RFP #015-96 allowed for recruitment but not full VBIO, she pointed out that the agencies awarded funding through the two proposal awards processes were only funded to cover behavioral risk populations (BRPs) 1-8. In addition to the neglect of BRPs 9-12, she identified a neglect of youth populations. She reminded the group present that many people had said that what gives them hope is "children," or "youth." However, no agency had been funded by the AIDS Office to provide Venue-Based Individual Outreach services to youth. She added that RAP had applied with SOS in response to RFP #016-96, because RAP respects the services that SOS provides.

  (**Note from Valerie:** Under RFP #015, Larkin Street Youth Services was funded to provide VBIO to youth. In addition, agencies funded to conduct VBIO under both RFPs will be expected to reach individuals of all ages.)

- *Skip Menifee of ICHO* said that he had worked 32 months as an outreach worker with SOS, providing services to African-Americans, IV drug users, sex workers, the homeless, and youth -- as well as to others at risk. He said that CHOWs in the Bayview area go beyond distributing condoms and bleach; they advocate for the clients and help empower them to survive. He explained that prevention work in this kind of community requires spending the time and providing the consistent prevention presence that it takes to build trust and credibility. After describing more of his work and experience in the Bayview neighborhood, Skip asserted that there has been a lack of representation of BCA on the streets and in the community, and he said that he could not support the funding of BCA to perform outreach.

- *Crystal Catamco of the Asian & Pacific Islander Wellness Center* said that she does outreach in the Tenderloin area -- specifically, she provides street and bar outreach services for the transgender community. She explained that she refers her clients into health and social services, and that her clients need her. In closing, she asked the HPPC to urge the AIDS Office to support SOS with more funding to do Venue-Based Individual Outreach.

- *Dianne Felix of Proyecto Contra SIDA por Vida* introduced herself as one of the founding members of the HPPC. She sat on the Council when the City was trying to put together a system to ensure the availability of HIV services to all people in San Francisco. She said that she had seen people in the room smirking at the comments about outreach, and she added that outreach workers had always been the underdogs in the process, with the lowest pay and with jobs that are often seen as unskilled. Dianne told the group present that she had started out as an outreach worker in the Gay Latino community, and she co-founded two organizations for this community in San Francisco. Observing the familiar faces in this room, she stressed that the providers had all had to learn how to do outreach work together. She said that she had then (and still has now) a lot of faith, and that the Council and community need to look at this process and its holes and inconsistencies. In closing, she testified that ICHO has done an excellent job of providing outreach services for the past three years, and that she could not imagine another organization taking on this work now.

- *Mark Bronnenberg of New Leaf* expressed his sense that there were genuine and significant errors made in the standard procedures for the RFP #016-96 awards. He informed the group that the New Leaf proposal had also not been funded, and said that the reviewers' comments indicated some errors in the actual reading and evaluating of the proposals (there were false statements, in some cases, about their content). Mark suggested that corrections should be made to account for these errors.

- *Dan Wohlfeiler of STOP AIDS Project* identified himself as another founding member of the HPPC. He stressed that, as prevention providers perform outreach services, they should remember that they cannot perform these services alone and cover everyone. He recognized that difficulties arise when a number of providers must divide a small piece of the pie (funding), and he said that the providers would have to work with each other in order to do a good job.

- *Hank Wilson of ACT UP Golden Gate* pointed out that this was an important time for the community to do valuable detail work. He said that people should not be mystified by the RFP review process -- that evaluators can make mistakes, have biases, and come with partial information. He asked the Council to consider what the awards decisions would do to neglected communities, and to the morale of providers. He asked whether the development by outreach workers of rapport, trust, and confidence with clients over time was valued. In closing, he said that the Council has the opportunity to express its concerns and understanding of the situation, and that members can use this potential to create change. He added that, without this role of the HPPC, the AIDS Office could just do whatever it wanted.

- *Clark Taylor of City College of San Francisco* said that, year after year, someone always asks whether this is a level playing field for providers. He stated that it is not a level field. In the case of City College, which applied for testing and counseling money to continue a program, the proposal was ranked fifth out of eleven agencies. However, the proposal from SFGH, which was ranked ninth of these eleven, was moved ahead and awarded funding instead (a total of five counseling and testing awards were made). He said that City College's appeal was met with the response that the RFP had specifically called for the funding of SFGH to do testing and counseling.

- *Tony Molina of the California Planning Working Group* said that he does not belong to the HPPC because some people at the AIDS Office can't stand him; and he added that he prefers to be in this outsider position. He said that he has been talking for years and years about prevention street outreach, and that people don't want to hear about public sex and sex work in the streets. He stated that he had sex in the parks, and he stressed that not enough providers are actually going to those places where people are engaging in risk behaviors. Tony added that English is not his first language, and expressed his concern that white people are going to be funded to reach his ethnic community and population.

HPPC Response to Public Comment

Joshua stated that he felt embarrassed as a member of the HPPC process, because the Council has had to have community members come in at different points to explain what isn't working. He said that he had had difficulty putting his own finger on what had gone awry in the process and when it had happened. Referring to the "Strategies and Interventions Chapter" of the S.F. HIV Prevention Plan, he noted that the definition of Venue-Based Individual Outreach clearly states that outreach

workers should come from the community they are serving, should develop prevention relationships with clients, and should maintain an ongoing presence in the community. He then said that he was concerned that some of the agencies funded for this intervention did not have these necessary qualities or relationships, while a group that had been doing the intervention for some time was underfunded. He added that it was still unclear, for those agencies funded, *which* populations they would be serving. Specifically, he identified an apparent lack (among agencies funded for VBIO) of cultural competency for reaching Native American and Asian and Pacific Islander populations; and he reiterated Marjorie Katz' point that only one agency had been funded to do outreach work with youth, and that this work was limited to recruitment into services (under #015). (**Note from Valerie:** See clarification under Marjorie Katz' public comment.)

Joshua also expressed his sense that, in this time of transition to a new RFP process and new prevention requirements, a group with a strong track record in performing outreach should not have had its funding so severely cut simply because of a low score on its proposal. He said that the awards decisions seemed to suggest that relationships between outreach providers and their target communities did not matter.

Joshua noted his discomfort with the idea of an East Bay agency coming into San Francisco to provide outreach services here, as well as with the apparent inconsistencies around using proposal scores to determine funding amounts. In the case of SFGH, it did not appear that the proposal score had a major impact on the award, whereas the SOS proposal score seemed to override the experience and the track record established by the collaboration. In closing, Joshua pointed out the large decrease in the amount of funding available for street outreach (he calculated a loss of about $900,000 for this intervention). He asked where the money had gone, and urged the HPPC to look "hard, fast, and furious" at this RFP process.

Liz supported Hank Wilson's comments, which she said pointed up the purpose and role of the HPPC. She expressed her hope that the community would understand how disappointed and appalled members of the HPPC are at the results of the RFP process. She added that, on the one hand, the award to CAL-PEP shows some needed attention to the community of sex workers -- but, on the other hand, it doesn't make sense to discontinue the SOS collaboration.

Ellen addressed a few different areas touched on in the comments. She clarified that Council members were not part of the actual funding decisions, which were the purview of the DPH alone. The establishment of standards for service provision, an evaluation plan, and the focus on behavioral risk were all decisions within the purview of the Council. Through these kinds of qualitative decisions, the HPPC had input into the development of the RFP, but many of the Council members were upset by what came out in the RFP itself, and none of the members were involved in funding decisions.

Ellen said that she was interested in having a Council discussion about how to respond to the Health Commission's recommendations. She pointed out that, while the HPPC does not have authority to reverse the funding decisions, it can appeal to other bodies. She added that the HPPC could look at mechanisms for bringing the technical review process back to the HPPC process, but that it would be important to watch out for possible conflicts of interest.

Ellen also suggested that the HPPC investigate the question of how the points influenced the actual awards, and look into the reasons for having to fund SFGH. She stressed the need to separate the Council's work in 1994, 1995, and 1996 from the outcomes of the RFP process. In closing, she

expressed her hope that the Council would be able to respond in some way to the recommendations of the Health Commission.

Chata stepped out of his co-chair role to speak about the need to define and to develop cultural competence, which first requires an understanding of what makes up culture. He read a definition of culture, and stated that the lack of cultural competence, combined with the HIV pandemic, produces a particularly devastating form of human suffering. (Chata's specific written comments are enclosed for all members.)

Ana Claire noted that, as two of the tasks for 1997, the HPPC would be reviewing and evaluating the RFP process and setting standards and criteria for cultural competence in prevention services.

Barbara addressed the members of the public present, to say that people often attend HPPC meetings to give public comment, and then leave at the end of that part of the agenda. She explained that the HPPC members would be discussing RFP-related issues later in the meeting, and she invited community members to stay, and to return to attend other HPPC meetings. She suggested that it would be valuable to have community members attend consistently, so as to continue to give input and to hear more of the HPPC process.

5. REQUEST FOR HPPC LETTER OF SUPPORT

HIV Program Director Cynthia Cunningham of Iris presented a proposal for a community-level intervention with minority women who are at risk for HIV because of drug abuse and/or unprotected sex. (The letter to the HPPC about the Iris proposal is enclosed for those absent.) She said that Iris had been running this program with CDC funding for the past four years, and that the new RFP (CDC Prevention Program Announcement #704) requires a close following of HPPC guidance expressed in the Plan.

Maria pointed out that more than one applicant agency might be qualified, and asked how the Council could respond to this request without knowing about the other proposals, in this competitive funding situation. Valerie responded that proposals were due January 6th, 1997, and that the applicants were not required to obtain an HPPC letter of support for their intervention proposals. She reminded the group that there was no other HPPC meeting scheduled to occur before this January 6th deadline.

Ellen supported Maria's point. She pointed out that the HPPC had set up a specific procedure for handling researchers' requests for letters of support, and said that she felt uncomfortable with the idea that, in a case such as this one, the HPPC could appear to be giving its support to one agency over another (when, in fact, the HPPC was unaware of the other proposals being submitted).

Sacul spoke to say that women, and especially women of color, have been ignored for prevention services in San Francisco. She stressed that the letter of request indicates that 75% of the Iris Center staff are women of color, and that the clients for the intervention would also be women of color. For these reasons, she said that she was inclined to give support to this proposal.

Hector noted that, with research proposals, San Francisco is competing with other cities in the U.S., and that it is important for the HPPC to support San Francisco-based research. He pointed out the differences in this situation, in terms of the smaller amount of money at stake, and the factor of competition between San Francisco agencies. In this case, he felt that the Council should not penalize Iris for taking initiative in asking for a letter of support for an intervention proposal.

However, he thought that, if the HPPC was going to be providing letters of support for proposed interventions, then it should send out a notice to CBOs informing them of the opportunity to request these letters. He said that the question remained as to whether the HPPC could support *only one* proposal responding to a particular prevention RFP, or why the HPPC would do this. Liz responded that the HPPC should be able to give letters of support to multiple agencies.

Steven said that this raised a process question; he didn't think that it was the place of the HPPC to give letters of support specific to any one RFP. Instead, he felt that the HPPC could draft a letter supporting an agency and its work -- addressing the general character and capability of the agency.

Jimmie stated that what's fair for one should be fair for all, and that the HPPC should develop a procedure in keeping with the procedure for researchers' requests for letters of support. He explained that he felt the HPPC would need to assess gaps in service and then provide a letter of support based on the capabilities of the applicant (as seen within the spectrum of citywide services) -- and not necessarily on the specific quality of the proposal. At this time, the HPPC could not perform this kind of review and decision-making process.

Joel expressed his sense that it is fair and strategically wise for people to come to the HPPC and request letters to support their proposals. He agreed with other members that, if the HPPC could give this kind of support, then every applicant should be able to submit a request for a letter. Joel reiterated Hector's point about the small pot of money to be awarded, and he also reinforced Chata's and Sacul's points about the need to consider the cultural competency of the applicants. **Joel then made the motion that agencies interested in HPPC letters of support be given a week to ask for these letters, and that an announcement be sent out to all current prevention providers in San Francisco, to inform them of this opportunity. He added to the motion the caveat that the HPPC should be able to write multiple letters of support for prevention agencies applying for the same funding.**

The Vote (on the above-described motion):

In Favor:	**8**
Opposed:	**1**
Abstentions:	**4**

The motion carried. Valerie stated that the AIDS Office would send to all prevention providers a notice advising them of the availability of a letter of support for CDC Prevention Program Announcement #704, and giving them a week to submit requests. Iris would be included in this mailing. (The memo faxed to prevention providers on December 19 is attached for all members.)

6. BREAK

7. RFP UPDATE

Valerie re-distributed the list (sent to the full Council prior to this meeting) of awards for RFPs #015-96 and #016-96, along with a key explaining the shorthand used in the tables (enclosed for those absent). She asked that people ignore, for now, the "proposed intervention" column, since its contents refer to what the provider proposed, and not to what the provider was then funded to do. With reference to the "recommended intervention" column, she explained that the AIDS Office had recommended these interventions, but that the actual interventions to be performed could change, depending on the contract negotiations process. She added that the asterisk indicates that some funding may be carrying over, affecting the total amounts for 1997. Because some agencies have

State or General funds that extend through June of 1997, the awards denoted with an * are actually 1998 award amounts. For the table showing funding awarded through RFP #016-96, Valerie noted that the "other characteristics" column for Iris should specify CSWs (commercial sex workers). She stated that the number of neighborhoods, populations, and other characteristics to be covered by a given agency with the funding awarded would not change from what was shown in the charts. She added that there would be $600,000 available for VBIO, in addition to the amounts (as yet unknown) awarded under RFP #015-96.

Valerie stated that the AIDS Office and DPH appreciate the comments made on the process and its results, and appreciate the pain of the changes being made to prevention services in the City. She said that providers are sharing a much smaller piece of the pie than they have in the past. However, she expressed confidence that the funded agencies would follow HPPC guidance, and she added that organizational development and technical assistance would be provided, along with ongoing evaluation, to support the agencies in meeting the new prevention expectations. She noted that changes could be made to the prevention system as needed.

In brief explanation of the decisionmaking process, Valerie stated that review panels were formed to make recommendations on the proposals, which were then scored. The AIDS Office made separate recommendations, which -- along with the review panelists' recommendations and scorings -- were submitted to Dr. Mitch Katz, who serves as the ultimate decisionmaker on funding awards. There were a number of appeals to the awards process, all of which were investigated and denied by the DPH. Valerie asked the Council to support the funded agencies, and to assist them in carrying out the vision and direction of the HPPC.

Jimmie asked whether the "other characteristics" column could be revised to include covariates and co-factors (in keeping with the Resource Inventory design), and Valerie responded affirmatively.

Noting that English is not her first language and asking the Council for its patience, Maria said that she wanted to sit on the Council to represent her community, as well as her particular agency. She identified her community as the Latino population in the Mission neighborhood. She explained that, three years ago, cultural competency was an important factor for funding; and she stressed that having staff members who belong to the culture being served is an essential component of cultural competency. She noted that the population in the Mission was going to be targeted by three agencies that are not within the neighborhood or the community of the Mission; and that some of these agencies had applied to serve their own neighborhoods, but were assigned to the Mission.

Maria also said that she was bothered by the fact that nobody could say yet how much funding would be available for street outreach. She wondered what would be the process for the AIDS Office making these decisions in contract negotiations. She added that she was concerned that only one agency was serving BRP #8, and no agencies appeared to be serving BRPs 9-12 -- which were still priorities for the HPPC.

About her own agency's contract, Maria said that, under RFP #016-96, IFR had received money to do general education and multiple session groups -- but that IFR had not even applied to do multiple session groups. She said that, to do these interventions, the agency should have received more funding. (**Note from Valerie:** The AIDS Office had to make some educated guesses on proposals that did not use language from the Strategies and Interventions Chapter. In this case, what was proposed most closely met the description of Multiple Session Groups.) Finally, Maria asked why the table showing RFP #015-96 awards included the statement "Recommend not

funding Aguilas," in the "other characteristics" column for IFR/Aguilas. She explained that IFR and Aguilas are partners in a collaboration, and that the AIDS Office should have offered some warning and some explanation for this recommendation (she said that she hadn't even been informed of this caveat prior to this meeting). (**Note from Valerie:** This information was provided to other staff of IFR during initial contract negotiations with the AIDS Office.)

Joshua said that he did not believe that the evaluation process for proposals had gone well. He said that somewhere in the translation of recommendations -- from the committee level to the HPPC, to the RFP, to the RFP review process -- the communication failed, and the intent of the HPPC was not reflected in the final awards. Joshua reiterated his question about what had happened to the additional $900,000 that was previously available for street outreach services, and he said that the HPPC should address what happened at the last Health Commission meeting. Valerie responded that she believed that the AIDS Office was asked to investigate the review process, and to report back to the Health Commission. Sacul added that the Health Commission was upset, not just for the CHOWs, but for their clients. She clarified that the AIDS Office would have to get back to the Health Commission with some kind of resolution by December 17th (the Tuesday following this Council meeting).

Valerie offered the following correction: SOS had been previously funded at $855,000 for 1996. They **applied** for $1.5 million for 1997. She reminded the group that there was never a commitment to keep all interventions funded at the same level, and that the AIDS Office tried to reach the highest-risk groups, while splitting the funding between the two RFPs. Valerie added that, following contract negotiations, the amount of funding in VBIO would probably be similar to the previous amount.

Barbara said that she feels strongly that there should be some review of the process for RFPs and funding awards. She expressed her understanding that people's comments in the review were not always reflected in the awards decisions. She said that she was concerned about how the recommendations and requirements were translated.

Ana Claire pointed out that one of the HPPC tasks for 1997 involves a review of the RFP process. She asked whether the Council was considering a more immediate action step now. Members responded that they would like to give a more immediate response, that comments on the proposals were very subjective, and that it would be important for the HPPC to gain more information about the appeals and why they were all rejected.

In response to members' questions about the actual content of the Health Commission's recommendations, Sacul explained that the Health Commission had requested that the DPH investigate the situation (around the awards decisions for 1997 prevention contracts), and deliver a report to the Commission at its meeting on Tuesday, 12/17. Sacul stated that the Commission had also suggested that the HPPC urge the AIDS Office to reconsider its awards decisions, and to support the SOS collaboration, which has three years of experience in providing prevention outreach services to at-risk populations in San Francisco. **Sacul then made a motion that the HPPC form an ad hoc committee -- including at least one Health Commission member, one HPPC member, and one community member (not on the payroll of any of the prevention funding applicants) -- to investigate the RFP review process, and to articulate concerns regarding:**

- **inconsistencies in the review process;**

- **requirements in the RFP that agencies have at least two years of experience performing prevention outreach services in San Francisco; and**
- **points assigned to proposals but not reflected in the funding awards.**

Discussion
Sacul explained that the Council would have to act quickly in order to produce a response in time for the 12/17 Health Commission meeting, and she added that, as a Council member, she did not want to have to carry the responsibility for this "mess" (the awards decisions).

Joshua said that he liked the bulk of Sacul's motion, but questioned whether the HPPC would be able to insist that a Health Commission member serve on the ad hoc committee. Isabel asked to add to the list of concerns the **contradictions between statements made in the Bidder's Conference and the text of the actual RFP.** She explained that this discrepancy related to the lower priority of female populations. She also asked what actions might result from this process of the ad hoc committee; she wondered whether this body would have any power to override the rejections of the appeals. She added that the fact that every one of the appeals was refused suggests a problem with the process.

Joel agreed with Isabel's point that additional concerns should be added to the list offered by Sacul. He said that the Council should look at why some proposals did not gain funding, and he expressed his concern for the clients who would be abandoned in San Francisco.

Jimmie voiced his feeling that the Resource Allocation and Resource Inventory Committee ought to be involved in the ad hoc committee process, should such a committee be formed. He explained that this input (from the committee that worked most closely on the recommendations for the RFP) would be important for keeping some consistency, and some connection to the history of the HPPC's RFP-related guidance.

Natalie said that, with the awards decisions made and the appeals denied, she felt that something should be done to stop the process, and to follow through in any way that the HPPC can. She said that, if time had to be taken away from other tasks, then that sacrifice should be made, in order to deal with the issue at hand. She stressed her concern about appeals being denied across the board, and said that she felt the HPPC members should do whatever is in their power to do.

Ana Claire asked Valerie and Gene if the Health Commission could overturn the decisions on the appeals, and they responded that they didn't think that that was within the Commission's purview. Ana Claire said that this didn't mean that the Council couldn't do anything. She suggested that the Health Commission and the HPPC look into the process, and particularly the denial of the appeals; but she added that she was unsure how the investigation could come to influence the funding or the configuration of street outreach services.

Steven said that he felt the Council should communicate the feelings expressed here to the Commission. He explained that -- though the Council doesn't know all of the details of the process of review, appeals, and denial of the appeals -- members can tell the Health Commission that they are uncomfortable with the way that funding looks now.

Liz stated that the most recent HPPC-generated proposal to write a letter of protest to the AIDS Office had not really gone anywhere. She expressed her concern about what the ad hoc committee

couldn't do, and said that she wanted to take immediate action. She added that there is a problem with the idea of taking away funding from agencies.

Sacul's motion was restated and amended, with the additions of the concerns about (1) contradictions between statements at the Bidder's Conference and the actual RFP, (2) statements made in the RFP but not carried out in the review/awards process, and (3) the level of cultural competency of the agencies funded (in terms of gender, ethnicity, class, etc.).

Hector asked what the committee could do and when. He described the issues under discussion as large and complex. He asked the Council to consider what results could be expected, and when, from the formation and activity of such an ad hoc committee. He also mentioned the connection between this proposed process and the other evaluation processes scheduled as HPPC activities.

Ana Claire clarified that the committee action would represent a further investigation of the process by the HPPC (in addition to the investigation by the Health Commission, and the RFP process review taking place in 1997). Joshua listed the following three action steps:

1) Ad hoc committee formation, investigation, and report to the Health Commission on 12/17;
2) HPPC letter of support to the Health Commission; and
3) AIDS Office evaluation and report to the Health Commission.

Ana Claire pointed out that the idea of a letter of HPPC support and concerns was a separate proposal from the proposal of a committee -- especially when a committee will already be put in place in 1997 to look at the RFP process and decisionmaking. Natalie expressed her sense that the HPPC letter should make a stronger statement, reflecting today's comments. At this point, **Ana Claire made a motion that, instead of focusing on the ad hoc committee, the HPPC empower a group of members to write a letter to the Health Commission -- and discuss the letter's contents at this juncture. She proposed that the letter incorporate all of the concerns listed earlier, in relation to Sacul's motion.** Then Ana Claire asked who would be able to work on writing the letter. (Barbara, Joshua, Ellen, Sacul, Natalie, and Jimmie volunteered their services.)

After being suggested as a person who could head the letter-writing effort, Vic explained that he had served on the review committee, and that the work was very subjective and difficult. It was hard, he explained, to compare credentials and statements of qualification. While there were agencies that he believed could support people in need with good services, some of those agencies had nothing substantial in their proposals. He agreed to help with the letter if he could, but said that he did not like being volunteered for the effort in a way that put him on the spot.

Sacul agreed to head the letter-writing effort, and members suggested that the product be brought back to the Council (in the form of a mailing prior to the January meeting). In the momentary absence of a quorum, Ana Claire took a straw poll on this motion for a letter-writing effort.

Straw Poll:	
In Favor:	9
Opposed:	0
Abstentions:	2

Natalie asked whether it was possible for the HPPC to refuse to accept the AIDS Office awards decisions. Valerie responded that, while members could state their disagreement, it was not within the purview of the HPPC to refuse to accept the awards.

8. ADOPTION OF 1997 PLAN

Lyn Paleo quickly presented the planned changes to the existing draft of the 1997 S.F. HIV Prevention Plan:

- ⇒ it will be referred to as the 1997 Plan (not the 1996 Plan);
- ⇒ there will be a more extensive dedication, written by Ana Claire;
- ⇒ spellings of some names will have to be corrected (in the lists of contributors);
- ⇒ tables for the Epi. chapter will have dates of the data collection for the studies;
- ⇒ the terminology around partners will be unified ("primary" and "other" will be used);
- ⇒ there will be copy-editing of the entire document;
- ⇒ the index will be completed; and
- ⇒ in chapter 5, p.522 will be revised -- the Appendix will include a paragraph regarding how the letter of concurrence procedure was adopted.

Lyn expressed her pride in the Council's achievements, and said that she hoped the Plan does justice to the members' work.

Ana Claire congratulated the Council on its work on the Plan and other tasks. She said that the work that the members do as a Council keeps her going in this process. Chata also expressed his pride in the Plan, and encouraged the Council to take pride in its completion. He read a longer statement (enclosed for all members).

Joel asked what pieces of the Plan speak to the HPPC's commitment to high-risk populations, people of color, and cultural competency of services. Ana Claire said that the 1994 HPPC had created a task to focus on issues of cultural competency, and that the HPPC would be working on this objective. Ellen added that cultural competency is a baseline requirement for all prevention activities to be funded by the AIDS Office (see the "Strategies and Interventions Chapter" standards for service provision). She also pointed out that issues of cultural competency are discussed in the "Epidemiological Profile" and "Future Directions" chapters.

Valerie thanked Harder + Co. and Polaris, Inc. staff for their work on the writing of the Plan.

With a quorum present, **the motion was made for the Council to adopt the 1997 Plan, with the changes outlined above.**

The Vote	
In Favor:	**9**
Opposed:	**1**
Abstentions:	**2**

The motion to adopt the Plan, with the above-mentioned changes, carried by a majority.

Since a quorum was still present, Ana Claire repeated the motion discussed earlier:

> **A group of HPPC members, acting on behalf of the HPPC, will write a letter to the Health Commission, supporting the Commission's recommendations and expressing concerns about the RFP process, including:**
>
> - **inconsistencies in the review process;**

- **requirements in the RFP that applicant agencies have at least 2 yrs. experience performing outreach in San Francisco -- and other points in the RFP that were not upheld in the awards decisions;**
- **the fact that points awarded were not reflected in the funding awards;**
- **the low priority of women (esp. women of color) reflected in the awards decisions;**
- **the contradictions between statements made by DPH staff at the Bidder's Conference and the text of the actual RFP; and**
- **the level of cultural competency of the funded applicants (e.g., regarding race, ethnicity, gender, and class).**

The Vote

In Favor:	**10**
Opposed:	**0**[1]
Abstentions:	**2**

The motion to write a letter for delivery to the Health Commission by Tuesday, and for copying to HPPC members prior to the January meeting, carried. (**Update:** On December 30th, this letter, along with an introductory statement read to the Health Commission by Community Co-Chair Chata, was mailed to all HPPC members, consultants, and participating AIDS Office staff -- as well as to the agencies represented by guests at this meeting.)

9. PROCESS EVALUATION REPORT

With the meeting out of time, this report had to be postponed for another time. Dr. Kathleen Roe briefly explained (for new members) that the Process Evaluation Team is reponsible for taking and presenting members' feedback. She pointed out that the meeting evaluation forms and participant dialogue boxes (both of which are used to take anonymous input from Council members, and to allow for anonymous communication between the different planning participants) are essential to the ongoing evaluation process.

In reference to earlier Council discussions about membership issues, Joshua asked whether there was any plan for mentoring new HPPC members. Since the meeting had to end and people were already leaving, Ana Claire asked him to talk to her later.

10. MEETING EVALUATION

As at every HPPC meeting, members were asked to fill out their meeting evaluation and participant dialogue forms before leaving.

11. HOLIDAY PARTY

Those who were able to stay longer took part in the HPPC holiday party, which included food and a celebratory cake, as well as a "white elephant" gift exchange.

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[1] The vote shown here represents the official vote counted at the meeting. Following the meeting, someone testified that they had voted to oppose the motion for this letter (or had tried to, anyway). It appears that this vote of opposition was initially misidentified as an abstention, which explains why it did not show up in the count taken by myself (Mary Irvine) or by Ana Claire Meyer.

Enclosed with These Minutes (for all members):

- notes read during public comment (by Ed Florentino, Chente Matus, and Skip Menifee)
- statement read by Chata, regarding culture and cultural competency
- faxed notice (signed by the HPPC co-chairs) of the availability of HPPC letters of support for proposals responding to CDC Program Announcement #704
- statement read by Chata, regarding the adoption of the Plan
- calendar of HPPC-related meetings in January

Enclosed with These Minutes (for those absent):

- copy of the COPASA job announcement
- letter of appeal to the AIDS Office, from City College of San Francisco
- Iris Center's written request for an HPPC letter of support
- key to the RFP awards tables, and the tables themselves
- Stanford University letter advocating for SOS funding, and protesting the review process
- "HPPC 1996 Chron Log: Update 11/14-12/12/96"
- "Evaluation Results" and "Participant Dialogue" from the 11/14/96 meeting

Important Note: Because there were so many guests at this meeting and full minutes packets cannot be furnished to each person who attended, an effort is being made to send at least one minutes packet to each agency represented. Those who receive this mailing are strongly urged to share the minutes and attachments with their co-workers who attended as members of the public. Thank you for your consideration.

Optional Meeting with Dr. Katz: January 15, 1997, 2-4pm, at the AIDS Office -- 25 Van Ness
Next Regular Meeting: January 23, 1997, 3-6pm, in the First Unitarian Church -- 1187 Franklin
(Please Note: The HPPC meeting originally planned for January 9, 1997 has been cancelled.)

Minutes Recorded by: Mary Irvine
Minutes Approved by: AIDS Office staffperson Valerie Kegebein and Community Co-Chairs Chata (Ronnie Ashley) and Ana Claire Meyer